

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034211  
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8787

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>East St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Little Rock Hospital, Inc.</b>		Length of stay in lb		d. STREET ADDRESS <b>1434 North 52nd. St</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Eli</b> Last <b>Forsee</b>			4. DATE OF DEATH Month <b>September</b> Day <b>10</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1889</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Ass't. Yardmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>ASHLAND MO</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>ELI FORSEE</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA ROBERTS</b>		14. NAME OF HUSBAND OR WIFE <b>Ada FORSEE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or bases of service)		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>BELLEVILLE ILL.</b> <b>EDWIN FORSEE JR</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
DUE TO (b) <b>Coronary Artery Arteriosclerosis</b>					<b>Several years</b>
DUE TO (c) <b>Arteriolar nephrosclerosis</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.1</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year o.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>July 1958</b> to <b>Sept 10 '58</b> and last saw her alive on <b>Aug 2 1958</b> Death occurred at <b>5:05P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Paul Smith M.D.</b>			22b. ADDRESS <b>Mo. Pac. Exp. Hosp.</b>		22c. DATE SIGNED <b>9-11-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>SEPT 13, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. HOPE</b>		23d. LOCATION (City, town, or county) (Sign) <b>BELLEVILLE ILL.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Burke Montuary - 3300 State Str.</b>			25. DATE RECD. BY LOCAL REG. <b>SEP 1 1958</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith MD</b> <b>mjb</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

East St. Louis, Illinois.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Chas M. Bush* .....

Licensed Embalmer No. *2421* .....

P. O. Address *East St. Louis* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.