

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037747

STATE FILE NUMBER

9891

76757-58
FILED OCT 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SAINT LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1		Length of stay in lb 227		d. STREET ADDRESS (If outside, give location) 2306 A CHOUTEAU	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Edwards			4. DATE OF DEATH Month Day Year Oct. 5, 1958		
5. SEX MALE 2	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/58	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME CAL EDWARDS		13b. MOTHER'S MAIDEN NAME HALLIS	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT ST. LOUIS CITY HOSP. #1.		Address			
18. CAUSE OF DEATH (Not only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Neonatal atelectasis DUE TO (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 762.5					INTERVAL BETWEEN ONSET AND DEATH 8-10 HOURS
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.) 762.5			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 10/5/1958, to 10/5/1958 and last saw her/him alive on 10/5/1958 Death occurred at 10.30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE James F. M. - Cool M.D.		22b. ADDRESS 1515 Lafayette Ave		22c. DATE SIGNED 10/6, 1958	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-31-58		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) St. Louis, Mo.		23e. (State)			
24. FUNERAL DIRECTOR Rowland Aker / 4104 Manchester		25. DATE RECD. BY LOCAL REG. OCT 16 '58		26. REGISTRAR'S SIGNATURE J. Carl Smith MD	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Licensed Embalmer No.

P. O. Address

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.