

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045606
STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

12666

300
-57

| | | | | | | |
|--|----------------------------------|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>01 5227 Kensington</u> | | Length of stay in 1b <u>8 yrs. 125</u> | d. STREET ADDRESS (If outside, give location) <u>5227 Kensington</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Warren Edwards</u> | | | 4. DATE OF DEATH Month Day Year <u>12 28 1958</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 2, 1923</u> | 9. AGE (In years last birthday) <u>35</u> | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Decorator--painter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>self</u> | 11. BIRTHPLACE (City and state or country) <u>Eads, Tennessee</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>John Edwards</u> | | 13b. MOTHER'S MAIDEN NAME <u>Samella Yancey</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>---</u> | 17. INFORMANT Address <u>Samella Butler 5227 Kensington</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ | | | | | | |
| DUE TO (c) _____ | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>410X</u> | | | |
| 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 Death occurred at <u>See 10/1955</u> and last saw him alive on <u>See 1/1958</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE <u>H. E. Edwards M.D.</u> | | (Degree or title) | 22b. ADDRESS <u>3136 Chautau</u> | | 22c. DATE SIGNED <u>12/28/58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>12/31/58</u> | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) <u>Memphis, Tennessee</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Charles J. Gates 4107 Finney</u> | | 25. DATE RECD. BY LOCAL REG. <u>DEC. 30 '58</u> | 26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Rayton Brown*

Licensed Embalmer No.4580.....

P. O. Address4107...Finney...

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.