Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003703
STATE FILE NUMBER

FILED FEB 10 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 291

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Clayton — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis Co. Hospital — Length of stay in 1b 7 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Maryland Hgt's. 4000 — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) Gen. Del. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Baby Girl Middle "Twin A." Last EDWARDS

4. DATE OF DEATH Month 1 Day 3 Year 59

5. SEX Female

6. COLOR OR RACE 3 Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ 0 DIVORCED ☐

8. DATE OF BIRTH 12-27-58

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 7 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Clayton, Missouri, USA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Bert Edwards

13b. MOTHER'S MAIDEN NAME Earline Bates

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)

16. SOCIAL SECURITY NO. None

17. INFORMANT St. Louis County Hospital, Clayton — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) ALSO FOCAL ATELECTASIS
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: ? from Birth

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 ☐ NO ☐ 0

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 12-27-58, to 1-3-59 and last saw her alive on 1-3-59
Death occurred at 1:40 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Bert Gowen MD 0

22b. ADDRESS 601 So. Brentwood

22c. DATE SIGNED 1-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

23b. DATE 1-30-59

23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory

23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR County Hospital, Clayton — ADDRESS

25. DATE RECD. BY LOCAL REG. 1-30-59

26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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.