

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006906

STATE FILE NUMBER

2-1152

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

FILED FEB 17 1959

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Missouri Baptist** Length of stay in 1b _____
d. STREET ADDRESS (If outside, give location) **1819 S. 11th. St.** Reside on Farm Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Mo.** b. COUNTY _____
c. CITY OR TOWN **St. Louis** Inside Limits Yes No

3. NAME OF DECEASED First Middle Last **Edwin C. Blase** 4. DATE OF DEATH Month Day Year **Jan. 31, 1959**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH **Feb. 15, 1878** 9. AGE (In years last birthday) **80** IF UNDER 1 YEAR Months Days **11 16** IF UNDER 24 HRS. Hours Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Carpenter** 10b. KIND OF BUSINESS OR INDUSTRY **Shapleigh Hdw. St. Louis, Missouri** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Fred Blase** 13b. MOTHER'S MAIDEN NAME **Elizabeth Koenig** 14. NAME OF HUSBAND OR WIFE **Josephine (Deceased)**

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. **499-01-4648** 17. INFORMANT **Charles C. Blase** Address **3515 Tennessee**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **arteriosclerotic heart disease**
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **generalized arteriosclerosis**
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) **4200**

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

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 **11-18-47** to **1-30-49** and last saw him alive on **1-30-49**
Death occurred at **8:45 A.** in on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **A. J. Merklein M.P.** 22b. ADDRESS **3507 Paloma** 22c. DATE SIGNED **2-2-49**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **Feb. 3, 1959** 23c. NAME OF CEMETERY OR CREMATORY **Sunset Burial Park** 23d. LOCATION (City, town, or county) (State) **St. Louis, County, Mo.**

24. FUNERAL DIRECTOR **Schumacher's** ADDRESS **3013 Meramec St.** 25. DATE RECD. BY LOCAL REG. **FEB 2 '59** 26. REGISTRAR'S SIGNATURE **Paul Smith, M.D.**

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. Marklin
Polina
100 P. 112.

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 *Jack Haupt*
Licensed Embalmer No. *4746*
P. O. Address *Haupt*

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.