

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010873  
STATE FILE NUMBER  
2 1900

MAR 18 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
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>Beverly Hills</b> 4160 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Baptist Hosp.</b>		Length of stay in lb <b>2 days</b>	d. STREET ADDRESS (If outside, give location) <b>7030 Greenway Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>J.</b> Last <b>Edwards</b>			4. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1869</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building Contr.-Ret.</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	9. AGE (In years last birthday) <b>89</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building Contr.-Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	11. BIRTHPLACE (City and state or country) <b>Devonshire, England</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>unknown Edwards</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Jarvis</b>
14. NAME OF HUSBAND OR WIFE <b>Amelia Edwards</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>
17. INFORMANT <b>Miss Merle Edwards, 7030 Greenway</b>		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) <b>Cerebral Hemorrhage</b>  Conditions, if any, which give rise to above cause (a), stating the underlying cause if known: <b>331x</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>AK</b> <b>3/23/59</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
19. WAS AUTOPSY PERFORMED? <b>YES</b> 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 _____ a.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>2-19-59</b> to <b>2-20-59</b> and last saw her alive on <b>2-20-59</b> Death occurred at <b>4:40</b> p. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Edward W. Coe M. D.</b>	
22b. ADDRESS <b>607 N. Grand, St. Louis 3, Mo.</b>		22c. DATE SIGNED <b>2-21-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>2/23/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>		ADDRESS <b>1905 Union</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 23 '59</b>
26. REGISTRAR'S SIGNATURE <b>Joan Smith, M.D.</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Edw. M. Cannon  
University Club Bldg.  
607 N. Grand  
Je. 3-4370

Hrs. 2-4 Sat.

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 *Albert R. Thompson*

Licensed Embalmer No. *4237*  
P. O. Address *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.