Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014937
STATE FILE NUMBER

FILED MAY 14 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4299

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis, Mo. — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis-Little Rock Hosp, Inc. — Length of stay in Ib: 24 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Pettis
c. CITY OR TOWN: LaMonte, Mo. — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS: Rt #1 (If outside, give location) — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Walter Middle: Benton Last: Edwards

4. DATE OF DEATH: Month: April Day: 28 Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 6, 1897
9. AGE (In years last birthday): 62 — 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): Pensr. Sheet Metal
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and state or country): Otterville, Missouri.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Riley Edwards
13b. MOTHER'S MAIDEN NAME: Francis Homan
14. NAME OF ~~HUSBAND OR~~ WIFE: Bernolia Edwards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): Nil.
16. SOCIAL SECURITY NO.: 702-16-1617
17. INFORMANT: Mrs. Doris Hayden, LaMonte, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: few days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Coronary Artery Disease — several year
DUE TO (c): 420.1
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 ☐

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 April 5, 1959, to April 28, 1959 and last saw ~~the~~ him alive on April 28, 1959
Death occurred at 11:00 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Benjamin N. Clark, M.D.
22b. ADDRESS: 1755 S. Grand Blvd.
22c. DATE SIGNED: 4-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 5-1-59
23c. NAME OF CEMETERY OR CREMATORY: I.OOF. Cemetery
23d. LOCATION (City, town, or county) (State): Ottersville, Mo.

24. FUNERAL DIRECTOR: Paul Moore Funeral Home ADDRESS: LaMonte, Mo.
25. DATE RECD. BY LOCAL REG.: MAY 1 '59
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. M O B

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

MAY 14 1959

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 Elton R. & Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis 7

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.