

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS JUL 24 1959

59-026586

2 6617

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hemer G. Phillips		d. STREET ADDRESS (If outside, give location) 5130 Lexington	
3. NAME OF DECEASED (Type or print) Margaret Edwards		4. DATE OF DEATH Month 7 Day 11 Year 59	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1939
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) E. St. Louis, Illinois
13a. FATHER'S NAME Theodore Neal		13b. MOTHER'S MAIDEN NAME Sylvia Poe	14. NAME OF HUSBAND OR WIFE John Edwards
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. Unknown	17. INFORMANT Theodore Neal East St. Louis, Ill.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Appendix with Generalized Peritonitis			INTERVAL BETWEEN ONSET AND DEATH undet.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> 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 _____ 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 7-7-59 to 7-11-59 and last saw her <input checked="" type="checkbox"/> alive on 7-11-59		Death occurred at 7:35 P m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Lemuel J. Clanton (Degree or title) Lemuel J. Clanton, M.D.		22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 7-14-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/17/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Marion Office, E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. JUL 14 59	26. REGISTRAR'S SIGNATURE Coard Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

S.P.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank Pichos pf

Licensed Embalmer No. 4356

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.