

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029691  
STATE FILE NUMBER

FILED VS SEP 14 1959 179

Registration District No. 179 Primary Registration District No. 4287 Registrar's No. 81

DED

1. PLACE OF DEATH a. COUNTY <b>Lincoln</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Troy</b>		Length of stay in 1b <b>24 hr.</b>		c. CITY OR TOWN <b>St Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>115 College</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1345 Hamilton Ave</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMA</b> Middle <b>GENE</b> Last <b>EDWARDS</b>				4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1959</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1958</b>		9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR. Months <b>2</b> Days <b>4</b> Hours <b>1</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Troy Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Roy Edwards</b>				13b. MOTHER'S MAIDEN NAME <b>Rose Lee Edwards Shelton</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Roy Edwards 1345 Hamilton Ave. St Louis Mo.</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <b>ACUTE BRONCHITIS</b>								<b>UNK -</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>BRONCHIOLITIS</b>								<b>UNK</b>		
DUE TO (c) <b>GENERALIZED VIRUS INFECTION</b>								<b>UNK -</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>EM. THYMUS</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<b>2. ABOVE CAUSES PRIMARY CAUSE OF DEATH LIMITED FOR POLIO CULT.</b>										
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 <b>—</b> s.m. <b>—</b> p.m. <b>—</b>		Month, Day, Year								
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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>ABOVE BY AUTOPSY ONLY</b> on the _____ of _____, 1959, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>Douglas Hella MD</b>				22b. ADDRESS <b>3716 E. WOOD, TROY, MO</b>				22c. DATE SIGNED <b>9/8/59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 11, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Troy Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Troy MO.</b>				
24. PUBLIC HEALTH DIRECTOR <b>D.W. McCoy Troy Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-8-1959</b>		26. REGISTRAR'S SIGNATURE <b>Charlotte Leek</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*D. W. McLaughlin*

Licensed Embalmer No. 3586

P. O. Address Froy Mo.

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.