

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037342

FILED VS OCT 27 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 410

ENDED

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| 1. PLACE OF DEATH a. COUNTY St Francois | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Francois | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre. | | c. CITY OR TOWN Bonne Terre | |
| Length of stay in 1b ** | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence | | d. STREET ADDRESS (If outside, give location) Rt 1 | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First * HATTIE Middle GERTRUDE Last EDGAR * | 4. DATE OF DEATH Month Oct Day 19 Year 1959 |
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|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12.6.1891 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Same | 11. BIRTHPLACE (City and state or country) Davisville, Mo | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME Harrison Hickman | 13b. MOTHER'S MAIDEN NAME Amanda Hickman | 14. NAME OF HUSBAND OR WIFE Firmin G. Edgar |
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| 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. ** | 17. INFORMANT Mrs Gilbert Graf Desloge, Mo. |
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| 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) Infarction of myocardium | | ? |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arteriosclerosis coronary thrombosis | Sev. yrs |
| | DUE TO (c) _____ | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic thrombophlebitis | 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year _____ |
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| 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 Bonne Terre, Missouri | COUNTY _____ STATE _____ |
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21. I attended the deceased from **1-11-54** to **10-6-59** and last saw ^{her}him alive on **10-6-59**
Death occurred **4:20** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
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| 22a. SIGNATURE <i>[Signature]</i> | (Degree or title) | 22b. ADDRESS Bonne Terre, Missouri | 22c. DATE SIGNED 10-23-59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Oct 22 1959 | 23c. NAME OF CEMETERY OR CREMATORY Bonne Terre Cemetery | 23d. LOCATION (City, town, or county) Bonne Terre, Mo |
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| 24. FUNERAL DIRECTOR C Z Boyer & Son Inc | ADDRESS Bonne Terre | 25. DATE RECD. BY LOCAL REG. Oct 23, 1959 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 19 1962

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

B. T. Boyer

B T Boyer

Licensed Embalmer No. 3660

P. O. Address Desloge, 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.