

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012549

FILED VS MAR 17 1960

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2 2779** STATE FILE NUMBER

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| 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, MO | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. | | d. STREET ADDRESS (If outside, give location) 3236 1/2 So. 13th St. | |
| Yes <input checked="" type="checkbox"/> No <input 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 Middle Last OSCAR B. EDMONDSON | | | 4. DATE OF DEATH Month Day Year MARCH 8, 1960 | | |
|---|--|--|--|--|--|

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|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/3/1887 | 9. AGE (last birthday) 73 | 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) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Walnut Ridge, Ark. | 12. CITIZEN OF WHAT COUNTRY U.S. |
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| 13a. FATHER'S NAME John Edmondson | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Myrtle Edmondson |
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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. None | 17. INFORMANT John Edmondson, 2352 So. 18th St. |
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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: IMMEDIATE CAUSE (a) Pulmonary edema | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Congestive heart failure | |
| | DUE TO (c) Tachycardia, unknown etiology | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 434-1 | | 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 | 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 **3/6/60** to **3/8/60** and last saw her/him alive on **3/8/60**
Death occurred at **11:55 A** on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|---|-----------------------------------|
| 22a. SIGNATURE Robert W. Moellenhoff, M.D. (Degree title) | 22b. ADDRESS 1515 LAFAYETTE AVE | 22c. DATE SIGNED 3/8/60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 3-10-60 | 23c. NAME OF CEMETERY OR CREMATORY Lane Cemetery | 23d. LOCATION (City, town, or county) (State) Walnut Ridge, Ark. |
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| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. | 25. DATE RECD. BY LOCAL REG. MAR 9 1960 | 26. REGISTRAR'S SIGNATURE Lois Smith, M.D. |
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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

Elton H. Penick

Licensed Embalmer No. 4258

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.