

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

2 4165 -60-016773

FILED VS. MAY 2 1960

STATE FILE NUMBER

INDEXED

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 <i>Missouri</i> by COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b <i>One year</i>		c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mason Hotel</i>			In the Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>250 So. 6th St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Henry</i> Last <i>Edwards</i>				4. DATE OF DEATH Month <i>April</i> Day <i>6th</i> Year <i>1960.</i>					
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 3, 1906</i>	9. AGE (last birthday) <i>53</i>	IF UNDER 1 YEAR Months <i>7</i> Days <i>9</i>	IF UNDER 24 HR Hours <i></i> Min. <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>		11. BIRTH PLACE (City and state or country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13a. FATHER'S NAME <i>unknown</i>			13b. MOTHER'S MAIDEN NAME <i>unknown</i>			14. NAME OF HUSBAND OR WIFE <i>unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>yes</i> <i>World War I</i>			16. SOCIAL SECURITY NO. <i>314-07-0178</i>		17. INFORMANT <i>Leelie Hansen</i>			Address <i>4553 Adkins Ave</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i> DUE TO (b) <i>arteriosclerosis</i> DUE TO (c) <i>422.1</i>							INTERVAL BETWEEN ONSET AND DEATH		
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 type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
20c. TIME OF INJURY Hour <i></i> a.m. <i></i> p.m. <i></i>		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 <i>9:20 A.M.</i> to <i></i> and last saw her/him alive on <i></i> . Death occurred at <i></i> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Paul J. Simon</i> (Degree of death) <i>Deputy Coroner</i>				22b. ADDRESS <i>300 Clark</i>				22c. DATE SIGNED <i>4/16/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 18, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Cemetery</i>		23d. LOCATION (City, town, or county) <i>Jefferson Barracks</i>		(State) <i>Mo.</i>		
24. FUNERAL DIRECTOR <i>Bree-Campbell Mortuary</i>			ADDRESS <i>1565 Delmar</i>		25. DATED BY LOCAL REG. <i>APR 16 1960</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>		

DOCUMENT

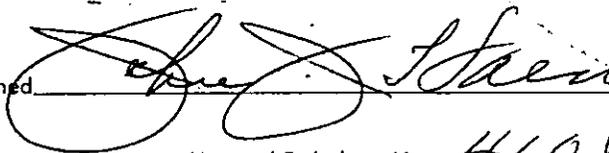
MEDICAL CERTIFICATION

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4108

P. O. Address Haen

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.