

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024469

FILED JUL 15 1960

318

Primary Registration District No.

1003

Registrar's No.

6544

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>En route to Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1008 Morrison</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Brenda Kay Edmond</b>				4. DATE OF DEATH Month Day Year <b>June 26 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>6 11 55</b>	9. AGE (last birthday) <b>5</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Michael Edmond</b>			13b. MOTHER'S MAIDEN NAME <b>Wilma Kelly</b>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Michael Edmond 1008 Morrison</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage, 2. Pulmonary edema, extensive, suffered when struck by car, operated by Dr. Sarpese, E. King in front of about 1304 S. 10th St. about 9:55 P.M. June 26, 1960. Accident</b>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>by car, operated by Dr. Sarpese, E. King in front of about 1304 S. 10th St. about 9:55 P.M. June 26, 1960. Accident</b>					DUE TO (c)	
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 checked="" 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.) <b>See above</b>			
20c. TIME OF INJURY <b>9:55 p.m.</b>	Hour	Month, Day, Year <b>6-26-60</b>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>1st street</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo.</b>		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>10:25 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <b>Joseph M. Quinn</b>				22b. ADDRESS <b>1300 Clark</b>			22c. DATE SIGNED <b>6-28-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>June 27 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Hope</b>		23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>			(State)
24. FUNERAL DIRECTOR <b>McLaughlin 2301 Lafayette</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JUN 28 1960</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b> <i>mjc</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Embalmer*

**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 *H. G. Ferris*

Licensed Embalmer No. *338*  
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.