

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony's Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>3534a Bamberger</b>	

3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Edinger</b> Last <b>Edinger</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>31</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1884</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Time Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lennox Hotel</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Phillip Edinger</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Elsie Edinger</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>492-40-3903</b>	17. INFORMANT <b>Elsie Edinger 3534a Bamberger</b>
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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) <b>Acute myocardial infarction</b>		<b>3 days</b>
DUE TO (b) <b>Diabetes mellitus</b>		<b>1 year</b>
DUE TO (c) <b>260x</b>		

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
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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
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21. I attended the deceased from **4-27-59**, to **8-31-60** and last saw him alive on **9-31-60**  
 Death occurred at **8:30** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John A. Hart M.D.</i>	(Degree or title)	22b. ADDRESS <b>3739 Gravois</b>	22c. DATE SIGNED <b>9-6-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Sept. 3, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hiram Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>
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24. FUNERAL DIRECTOR <b>Schumacher's 3013 Meramec St.</b>	25. DATED BY LOCAL REG. <b>SEP 3 1960</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>
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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 W. E. Morris

Licensed Embalmer No. 3360

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.