

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Affton	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If outside, give location) 9808 Ridgeley	

3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE J EDWARDS			4. DATE OF DEATH Month Day Year December 24 1960		
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 10/8/1908	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Robert R Edwards		13b. MOTHER'S MAIDEN NAME not known		14. NAME OF HUSBAND OR WIFE Margaret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW-II		16. SOCIAL SECURITY NO. 498-05-5846		17. INFORMANT Address Margaret Edwards 9808 Ridgeley	

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) <u>SPONTANEOUS SUBARACHNOID HEMMORHAGE</u>			<u>1 MONTH</u>
DUE TO (b) <u>ANEURYSM ANTERIOR CEREBRAL ARTERY</u>			<u>Unknown</u>
DUE TO (c) <u>330X</u>			

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 checked="" type="checkbox"/> NO <input 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 <u>Dec 1, 1960</u> to <u>Dec 24</u> and last saw her/him alive on <u>Dec 23</u> Death occurred at <u>9:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE <u>George H. Hartman, M.D.</u> (Degree or title)	22b. ADDRESS <u>3720 WASHINGTON, St. Louis</u>	22c. DATE SIGNED <u>Dec 25, 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE <u>12/27/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>
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24. FUNERAL DIRECTOR <u>John L Ziegenhein & Sons</u> ADDRESS <u>7027 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 27 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed G. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gra

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.