SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 13 1961 318 Registration District No. 1003 Primary Registration District No. 2078 Registrar's No.

61-010722 STATE FILE NUMBER

AMENDED

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS, MO
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #1.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ohio
b. COUNTY: Champaign
c. CITY OR TOWN: Mechanicsburg
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 18 Locust
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle F. Last EDWARDS
4. DATE OF DEATH: Month FEB. Day 27, Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: 3/24/1918
9. AGE (last birthday): 42
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Mechanicsburg, Ohio
12. CITIZEN OF WHAT COUNTRY: U?S.A.
13a. FATHER'S NAME: Clayton Edwards
13b. MOTHER'S MAIDEN NAME: Easie Ferryman
14. NAME OF HUSBAND OR WIFE: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W. W. # 2
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Clayton Edwards, 18 Locust, St. Mechanicsburg, Ohio.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumococcal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 493 x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Chronic Alcoholism; Delirium Tremens.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 2/23/61, to 2/27/61 and last saw her/him alive on 2/27/61
Death occurred at 9:45 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Francis Flury MD (Degree or title)
22b. ADDRESS: 1515 LAFAYETTE AVE
22c. DATE SIGNED: 2/28/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-1-61
23c. NAME OF CEMETERY OR CREMATORY: Maple Grove Cemetery
23d. LOCATION (City, town, or county) (State): Mechanicsburg, Ohio.

24. FUNERAL DIRECTOR: Albert H. Hoppe Inc., ADDRESS: 4700 Washington, Blvd
25. DATE RECD. BY LOCAL REG.: MAR 1 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

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_____ Signed Elmo R. Sadwell

Signature of Student Embalmer

Licensed Embalmer No. 4077

P. O. Address St Louis

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