

318

1003

3415

STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED APR 24 1961

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b _____ | c. CITY OR TOWN <u>St. Louis</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1341A Temple Place</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>1341A Temple Pl.</u> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | | |
|--|----------------------------------|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>Furlie</u> Middle _____ Last <u>Edgar</u> | | | 4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>61</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-25-1902</u> | 9. AGE (last birthday) <u>58</u> | 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) <u>Labor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u> | | 11. BIRTHPLACE (City and state or country) <u>Sarkville Miss.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Robert Edgar</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Viola Edgar</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or <u>type</u> of service) | | | 17. INFORMANT <u>Viola Edgar 1341A Temple Pl.</u> | | | |

| | | |
|---|------------------------|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Stenosis; embolus of liver.</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>410X</u> | |
| | 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 type="checkbox"/> No <input type="checkbox"/> Unknown | |
|---|--|--|--|

| | | | |
|--|---|--|--------------------------|
| 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.) | |
| 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 _____ |

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ 3:03 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|--|------------------------------------|----------------------------------|-----------------------------------|
| 22a. SIGNATURE <u>Jessie D. Jones</u> | (Degree or title) <u>Secretary</u> | 22b. ADDRESS <u>200 Clark</u> | DATE SIGNED <u>APR 11 1961</u> |
|--|------------------------------------|----------------------------------|-----------------------------------|

| | | | |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>4-11-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u> |
|--|-----------------------------|--|---|

| | | | |
|--|-------------------------------------|--|--|
| 24. FUNERAL DIRECTOR <u>Jackson Funeral Hm.</u> | ADDRESS <u>2649 Delmar Blvd.</u> | 25. DATE RECD. BY LOCAL REG. <u>APR 11 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Boad Smith. M.D.</u> |
|--|-------------------------------------|--|--|

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Leroy W. Ginnister

Licensed Embalmer No. 1523

P. O. Address 4251 Wash

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.