

No. 2
-1-4-41
-1-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40690

State File No. _____
Registrar's No. **10462**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 45 days (Specify whether
In this community 13 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 2900
(c) City or town St. Louis, (If outside city or town limits, write "RURAL") 9
(d) Street No. 2633 Delmar (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Edwards

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 3FE male 5. Color ed race _____ 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Chas. Edwards 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased: (Month) 5 (Day) 16 (Year) 1899

8. AGE: Years 42 Months 7 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Madendale Miss (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Raut

13. Birthplace Miss (City, town, or county) (State or foreign country)

14. Maiden name Mary Simpson

15. Birthplace Clarkdale Miss (City, town, or county) (State or foreign country)

16. (a) Informant Chas. Edwards

(b) Address 2633 Delmar

17. (a) removal (b) Date thereof 12 20 41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlily, Miss

18. (a) Signature of funeral director Thomas Raut

(b) Address 2734 Shenzlers Ave.

19. (a) DEC 31 1941 (b) J. J. Bredek (Date received for local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 25, 1941
year _____ hour 8 minute 30 A. M.
21. I hereby certify that I attended the deceased from December 10,
1941, to December 25, 1941
that I last saw her alive on December 25, 1941 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Glomerular Nephritis - Chronic
Duration Unk.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury 0

23. Signature J. W. Johnson (M. D. or other) _____
Address 2601 N. Chittier Date signed 12-29-41

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed..... *Chas. L. Howell*

Licensed Embalmer No. *2452*

P. O. Address..... *3028 Dickson*

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 this body is not embalmed, fact should be so stated above.