711
V. S. No. 2
00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 3 1945

State File No. 22738

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6669

1. PLACE OF DEATH:

(a) County

(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: City Hospital

Max C. Starkloff Memorial (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 64 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17 (If outside city or town limits, write "RURAL")

(d) Street No. 218 S. 4th 9 (If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME EDWARD WHITSON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive - - years

7. Birth date of deceased August (Month) 1 (Day) 1874 (Year)

8. AGE: Years 71 Months 11 Days 23 If less than one day - - hr. min.

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

10. Usual occupation unknown

11. Industry or business unknown

FATHER 12. Name James

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

MOTHER 14. Maiden name Maggie ?

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

16. (a) Informant R. Nation

(b) Address 1515 Lafayette Avenue

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-30-45 (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director

(b) Address

19. (a) JUL 30 1945 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1945 hour 11:50 minute P. M.

21. I hereby certify that I attended the deceased from May 21, 1945, to July 23, 1945, that I last saw him alive on July 23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address 1515 Lafayette Avenue Date signed 7/24/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.