

S. No. 2
M-8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25596

State File No. _____
Registrar's No. 7360

FILED SEP 1 1945
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Barnes Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **ILL.** (b) County **FRANKLIN 999**
(c) City or town **BENTON 11**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) **W. R. 2**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CHARLES EDWIN EDWARDS**
(b) If veteran, name war **NIL**
(c) Social Security No. **360-16-6561**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **8** day **22**
year **1945** hour **1** minute **45 P.M.**
21. I hereby certify that I attended the deceased from **8-21-45**
19____ to **8-22-45** 19____
that I last saw him alive on **8-22-45**
and that death occurred on the date and hour stated above.

4. Sex **M O** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **SINGLE!**
6. (c) Age of husband or wife if alive _____ years

Immediate cause of death **Cardiac failure** Duration _____

7. Birth date of deceased **MARCH 10 1924**
(Month) (Day) (Year)

Due to **Rheumatic Heart disease & mitral stenosis & regurgitation**

8. AGE: Years **21** Months **5** Days **12** If less than one day hr. _____ min. _____

Due to **pulmonary infarction in Rt. lung**

9. Birthplace **BENTON ILL I**
(City, town, or county) (State or foreign country)

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

10. Usual occupation **CLERK**

Major findings: Of operations _____
Of autopsy **as above**

11. Industry or business _____

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

12. Name **ORVILLE EDWARDS**

13. Birthplace **ILLINOIS I**
(City, town, or county) (State or foreign country)

14. Maiden name **ALICE HOLLAWAY**

15. Birthplace **ILLINOIS I**
(City, town, or county) (State or foreign country)

16. (a) Informant **ALICE EDWARDS**

(b) Address **BENTON, ILL.**

17. (a) **REMOVAL** (b) Date thereof **8-23-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BENTON, ILLINOIS**

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 _____

23. Signature **James H. Bradley** (M. D. or other) _____
Address **Barnes Hospital** Date signed **8-23-45**

18. (a) Signature of funeral director **ALBERT H. HOPPE**
(b) Address **4700 WASHINGTON**

19. (a) **AUG 23 1945** (b) Registrar's signature **J. F. Bredest**
(Date received local registrar) (Registrar's signature)

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 Albert G. Hoppe

Licensed Embalmer No. 2971

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.