

FILED APR 15 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

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1003

State File No. 9989
3000

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		c. LENGTH OF STAY (in this place) <u>16 YRS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		d. STREET ADDRESS (If rural, give location) <u>4334 WESTMINSTER PL. 0</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>4334 WESTMINSTER PL.</u>				d. STREET ADDRESS (If rural, give location) <u>4334 WESTMINSTER PL. 0</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>HERBERT</u> b. (Middle) <u>MAURY</u> c. (Last) <u>EDMUNDS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 1 - 1949</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>FEB-28-1873</u>		
9. AGE (in years last birthday) <u>76</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (State or foreign country) <u>DANVILLE VIRGINIA</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>STERLING E. EDMUNDS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY J. CLAIBORNE</u>		14. NAME OF HUSBAND OR WIFE <u>MARY A. EDMUNDS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mary A. Edmunds</u> ADDRESS _____				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Paralysis agitans (Parkinson)</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hemiplegia 12 yrs standing</u>					INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____						
22. I hereby certify that I attended the deceased from _____, 19 <u>35</u> , to April 1, 1949, that I last saw the deceased alive on <u>April 1</u> , 1949, and that death occurred at <u>9 A.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Wm Alexander Smith - M.D. (U)</u>				23b. ADDRESS <u>Webster Brown, MD</u>		23c. DATE SIGNED <u>4-2-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>4-4-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>APR 2</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parker Undertaking Co. - Web. Brown, Mo.</u>				

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

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.

Signed.....

Leslie Welch

Signed.....
Student Embalmer

Licensed Embalmer No. *4395*

P. O. Address *Robert Groves M*

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.