

FILED JAN 26 1950

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **440**

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

1. PLACE OF DEATH a. COUNTY S		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Belleville	
d. FULL NAME OF HOSPITAL OR INSTITUTION Shriners Crippled Childrens Hospital		d. STREET ADDRESS (If rural, give location) 614 Bristow	
3. NAME OF DECEASED (Type or Print) a. (First) Pamela b. (Middle) Eloise c. (Last) Edwards			4. DATE OF DEATH (Month) (Day) (Year) Jan. 13, 1950
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 9/20/1946
9. AGE (In years last birthday) 3		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Belleville, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Allen F. Edwards		13b. MOTHER'S MAIDEN NAME Peggy Bailey	
14. NAME OF HUSBAND OR WIFE -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No.	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Allen F. Edwards Belleville, Ill.	
MEDICAL CERTIFICATION			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary atelectasis (Post operative) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital hypertrophy lower Extremities 3 yrs. DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 40 min.	
19a. DATE OF OPERATION 1-12-50	19b. MAJOR FINDINGS OF OPERATION Cong. lymphangiomata & hemangioma Rt. lower Extremity Pulmonary atelectasis Extremity		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 7580 (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	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 7-1 , 1949 , to 1-13 , 1950 , that I last saw the deceased alive on 1-13 , 1950 , and that death occurred at 5 a. m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) George E. Scher M.D.		23b. ADDRESS Shriners Hospital, St. Louis, Mo.	
23c. DATE SIGNED 1-13-50		24. LOCATION (City, town, or county) (State) Belleville, Ill.	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1/13/1950	24c. NAME OF CEMETERY OR CREMATORY Walnut Hill	24d. LOCATION (City, town, or county) (State) Belleville, Ill.
DATE REC'D BY LOCAL REG. JAN 16 1950		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Belleville, Ill.	

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.

Body not embalmed.

Student
Student Embalmer

Signed *Peter Gardner*

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.