

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6144

State File No. ....

623

FILED FEB 21 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. ....

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>5 Days</b>		c. CITY OR TOWN <b>Overland</b> <b>423X</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				STREET ADDRESS (If rural, give location) <b>27 2896 Poe Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>Gust</b>		a. (First)		b. (Middle) <b>A.</b>		c. (Last) <b>Edin</b>	
4. DATE OF DEATH <b>Jan. 19, 1957</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>March 26 1878</b>		9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plastering Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plaster</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Edin</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>The Late Grace Edin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>501-09-4297</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Gordon Edin 2896 Poe Ave.</b>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
		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. <b>420.0</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input type="checkbox"/> 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) (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 <u>June, 1951</u> , to <u>Jan 19, 1957</u> , that I last saw the deceased alive on <u>Jan 18, 1957</u> , and that death occurred at <u>1:00 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>John J. Riley MD</b>				23b. ADDRESS <b>MO Theatre Bldg.</b>		23c. DATE SIGNED <b>Jan. 24, 1957</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Jan 23 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JAN 21 '57</b>		REGISTRAR'S SIGNATURE <b>Charles Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Collier Mortuary 10123 St. Charles Rd</b>			

(Licensed Embalmer's Statement on Reverse Side)

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..

Student.....  
Signature of Student Embalmer

Signed..... *Sheldon Collier*

Licensed Embalmer No. *338*

P. O. Address *10123 St.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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