RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS DEC 1 4 1960 318

-60-043541

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 11786

DED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Deaconess

Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY

c. CITY OR TOWN: St Louis

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 4147 Penrose

Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Leonard Middle: Gale Last: Edmonds

4. DATE OF DEATH: Month: Dec Day: 7 Year: 60

5. SEX: Male

6. COLOR OR RACE: White

7. ~~Married~~ ~~Widowed~~ ☐ Never Married ☒ ~~Divorced~~

8. DATE OF BIRTH: 12/6/60

9. AGE (last birthday)

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: 13 Min.: 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and state or country): Mo

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Leonard Gale Edmonds

13b. MOTHER'S MAIDEN NAME: Dorothy Louise Thompson

14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Dorothy Louise Thompson Edmond Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Neonatal Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 13½ hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c): 762.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/6/60, to 12/7/60 and last saw her/him alive on 12/7/60 8:18 AM

Death occurred at 8:14 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Herman N. Reas, M.D. (Degree or title)

22b. ADDRESS: 6500 Chippewa Street 95

22c. DATE SIGNED: 12/7/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 12-8-60

23c. NAME OF CEMETERY OR CREMATORY: Whitewater Cemetery

23d. LOCATION (City, town, or county) (State): Perryville, Missouri

24. FUNERAL DIRECTOR: McLaughlin ADDRESS: 2301 Lafayette

25. DATE RECD. BY LOCAL REG.: DEC 8 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.