

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-042359

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11076

AMENDED

<p>FILED DEC 1 1961</p> <p>1. PLACE OF DEATH</p> <p>a. COUNTY</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri.</u> b. COUNTY <u>Jefferson</u></p>		
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u></p>		<p>Length of stay in 1b <u>30 Days</u></p>		
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u></p>		<p>d. STREET ADDRESS (If outside, give location)</p> <p>Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>Reside on Farm <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></p>		
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Robert</u> Middle <u>J.</u> Last <u>Edmiston</u></p>			<p>4. DATE OF DEATH</p> <p>Month <u>November</u> Day <u>27</u> Year <u>1961</u></p>	
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>White</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>12/15/1890</u></p>	
<p>9. AGE (last birthday) <u>70</u></p>		<p>IF UNDER 1 YEAR IF UNDER 24 HR</p> <p>Months Days Hours Min.</p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Retired</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u></p>	<p>11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>J. Robert Edmiston</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Emma Blakeslee</u></p>		<p>14. NAME OF HUSBAND OR WIFE <u>Emma Edmiston</u></p>
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wt or dates of service) <u>Yes</u></p>		<p>16. SOCIAL SECURITY NO. <u>None</u></p>	<p>17. INFORMANT Address <u>Emma Edmiston, Antonia, Mo.</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>				<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>IMMEDIATE CAUSE (a) <u>BROUHPNEUMONIA, TERMINAL</u></p>				<p><u>ONE WEEK</u></p>
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>DUE TO (b) <u>MALNUTRITION, SEVERE</u></p>				<p><u>ONE MONTH</u></p>
<p>DUE TO (c) <u>CARCINOMATOSIS, ABDOMINAL, PRIMARY UNDETERMINED.</u></p>				
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>			<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p><u>199.2</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour Month, Day, Year</p>				
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>9-26-61</u> to <u>11-27-61</u> and last saw her/him alive on <u>11-26-61</u></p> <p>Death occurred at <u>5:30</u> <u>A.</u>m on the date stated above, and to the best of my knowledge, from the causes stated.</p>				
<p>22a. SIGNATURE (Degree or title) <u>Frederick W. Kling, M.D.</u></p>			<p>22b. ADDRESS <u>6500 Chippewa, St. Louis 9, Mo.</u></p>	<p>22c. DATE SIGNED <u>11-28-61</u></p>
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u></p>	<p>23b. DATE <u>11-30-61</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u></p>	<p>23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u></p>	
<p>24. FUNERAL DIRECTOR ADDRESS <u>Heiligtag Funeral Home, Imperial, Mo.</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>NOV 28 1961</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>Roald Smith, M.D.</u></p>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

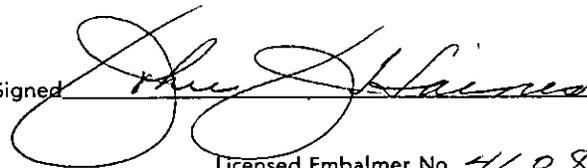
ITEM NO. SHOULD READ

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



Licensed Embalmer No. 4108

P. O. Address J. Haines

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.