

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-003419

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **376**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 84 yrs.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3311 Wisconsin
3. NAME OF DECEASED (Type or print) First HENRIETTA Middle Last EDLER			4. DATE OF DEATH Month January Day 10, Year 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/30/78
9. AGE (last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME August Mueller	
14. MOTHER'S MAIDEN NAME Clara Hess		15. NAME OF HUSBAND OR WIFE Fred E. Edler	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. [REDACTED]	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy		INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Arterio-sclerotic heart disease	
DUE TO (c) Diabetes Mellitus		2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260x		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour [REDACTED] Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Louis, Missouri	
21. I attended the deceased from Jan 10-63 to Jan 10-63 and last saw her/him alive on Jan 10-63 Death occurred at 11:15 A. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature]		22b. ADDRESS 3739 [REDACTED]	
22c. DATE SIGNED 1-13-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE Jan. 14, 1963		23c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery	
23d. LOCATION (City, town, or county) St. Louis, Missouri		24. FUNERAL DIRECTOR Beiderwieden F.H.Inc., 1936 St. Louis (6)	
25. DATE RECD. BY LOCAL REG. JAN 14 1963		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

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Dr. John D. Smith
3737 Broadway

Pr. 2-6377 11-30-130

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. 4520

P. O. Address Dr. Jones / Mo

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.