DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 7

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4224

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 1054

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Clarksburg NR
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME Laura Edwards

8. (b) If veteran, name war No.

8. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Loy

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased April (Month) 24 (Day) 1894 (Year)

8. AGE: Years 45 Months 9 Days 7 If less than one day hr. min.

9. Birthplace California (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Henry Peters

13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name Louise Kerchoff

15. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Loy Edwards

(b) Address California, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/2/40 (Month) (Day) (Year)

(c) Place: burial or cremation California, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) FEB 1 1940 (Date received local registrar) (b) [signature] (Signature of embalmer)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31 year 1940 hour 4 P minute 43 P.M.

21. I hereby certify that I attended the deceased from 1-22-1940, 19..., to 1-31-1940, 19...; that I last saw her alive on 1-31-1940, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis?	
Due to Following operation	
Due to Carcinoma of uterus following operation	
Other conditions (Include pregnancy within 3 months of death)	

Duration

Major findings: Of operations Carcinoma of uterus

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 3720 Washington Ave Date signed 1-31-40

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed. Guy W Wilkinson

Licensed Embalmer No. 2575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.