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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11381

Primary Registration District No. 1003

Registrar's No. 3418

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Kirkwood 91
(If outside city or town limits, write "RURAL")

(d) Street No. 156 W. Argonne N.R.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Larry D. Ives

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased January (Month) 31 (Day) 1945 (Year)

8. AGE: Years | Months 2 | Days 15 | If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Lawrence W. Ives
13. Birthplace Bellgrade (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Lois M. Cowley
15. Birthplace O'Fallon (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Lawrence Ives
(b) Address 146 W. Argonne

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) APR 17 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16 year 1945 hour 7:30 am minute M.

21. I hereby certify that I attended the deceased from 4-3-45, 19, to 4-16, 1945 that I last saw him alive on 4-16, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Perlusion	?
Due to	
Due Aspiration pneumonia	36 hrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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? (Specify type of place)
While at work? Means of injury

23. Signature [signature] (M. D. or other)
Address 3700 Washington Date signed 4/17/45

(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 Albert G. Hofafec

Licensed Embalmer No. 2971

P. O. Address.....

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