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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25793

State File No.

FILED SEP 1 1945

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 7376

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
St. Louis City Hospital #1. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17 10
(If outside city or town limits, write "RURAL")

(d) Street No. 4142 Greer Avenue 9
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Charles Iverson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race Wh

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

6. (b) Name of husband or wife Della Iverson

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

7. Birth date of deceased March (Month) 9 (Day) 1885 (Year)

8. AGE: Years 60 Months 5 Days 14 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Henry Iverson
13. Birthplace (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Sohpie Eric
15. Birthplace (City, town, or county) Germany 4 (State or foreign country)

16. (a) Informant Mrs Marie Hollembeck
(b) Address 5154 Palm St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/45 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefonraine Cem.

18. (a) Signature of funeral director Kraeger-Voss
(b) Address 3402 No. Kingshighway

19. (a) AUG 24 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 23rd year 1945 hour 1:20 minute A. M.

21. I hereby certify that I attended the deceased from 8/13/45, 19..., to 8/23/45, 19...; that I last saw him alive on 8/23/45, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhage from tracheotomy wound	3 yrs
Due to Ca larynx	
Due to	
Other conditions Gastrotomy (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? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address 1515 Lafayette 8/23/45 Date signed

(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.....

Licensed Embalmer No. 3575

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.