

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13712

State File No. \_\_\_\_\_  
Registrar's No. 507

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

2176  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hosps = 1		d. STREET ADDRESS (If rural, give location) 3700 S. Main St.			
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Dean Harvey Derikson			4. DATE OF DEATH (Month) (Day) (Year) 12 24 50		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH abt 1897	9. AGE (In years last birthday) 53	10. MONTHS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mk		10b. KIND OF BUSINESS OR INDUSTRY Mk		11. BIRTHPLACE (State or foreign country) Ky.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Mk		13b. MOTHER'S MAIDEN NAME Mk	
14. NAME OF HUSBAND OR WIFE Mk		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state year or date of service) Mk		16. SOCIAL SECURITY NO. Mk	
17. INFORMANT'S SIGNATURE OR NAME P. B. Vayn / 1300 Clark		17. ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		Cerebral Embolus			
DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 324X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) M. B. Vayn			23b. ADDRESS 1300 Clark		23c. DATE SIGNED 1/11/51
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE JAN 18 1951	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REGISTRAR JAN 18 1951		REGISTRAR'S SIGNATURE B. L. Foster		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	

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

*Students of Mortuary College*  
working under my personal supervision.

Student Embalmer No.....

Signed

*James A. Lammers*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

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.