

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 13 1954

State File No. **6464**  
Registrar's No. **2154**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>2237</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>23 920 Geyer Avenue.,</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH
a. (First) <b>Charles</b>	b. (Middle) <b>N.</b>	c. (Last) <b>Larrison</b>	(Month) (Day) (Year) <b>March 5 1954</b>

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan 10 1874</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Vienna, Illinois /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>James Larrison</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Campbell</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Larrison</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>Nil</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Edna Looney</b>	ADDRESS <b>2026 Victor Street</b>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Fracture of right hip.</b>		
ANTECEDENT CAUSES		DUE TO (b)	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		<b>Generalized Arterio Sclerosis; Suffered in fall on</b>	
II. OTHER SIGNIFICANT CONDITIONS		<b>Hospital, exact time</b>	
Conditions contributing to the death but not related to the disease or condition causing death.		<b>unknown</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Accident</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENTS (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Shop</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St Louis Mo</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>July 26 54 ?</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>E9047</b>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19 **54**, to \_\_\_\_\_, 19 \_\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19 \_\_\_\_\_, and that death occurred at **7:54 p.m.**, from the causes and on the date stated above. **45**

23a. SIGNATURE (Degree or title) <b>Patrick P. Taylor Coroners 3</b>	23b. ADDRESS <b>1300 Clark</b>	23c. DATE SIGNED <b>9.8.54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3-7-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Whistlewood Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Mounds, Illinois</b>
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DATE REC'D BY LOCAL REG. <b>MAR 8 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
*John J. Haines*  
Licensed Embalmer No. 40

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.