

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17207

FILED MAY 17 1954

State File No. \_\_\_\_\_

318

1003

Registrar's No. 4172

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____	
1. PLACE OF DEATH a. COUNTY <u>St Louis, Mo</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>IOWA</u> b. COUNTY _____			
b. CITY OR TOWN <u>St Louis Mo.</u>		c. LENGTH OF STAY (in this place) <u>8 DAYS</u>		c. CITY OR TOWN <u>Donnellson</u>		d. In 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 <u>St Louis Children's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>none</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>GARY</u> b. (Middle) <u>Lynn</u> c. (Last) <u>LATTA</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 9 1954</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9-21-51</u>		9. AGE (In years last birthday) <u>2 yrs - 7</u>	10. UNDER 1 YEAR <u>18</u>	11. UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>FORT MADISON, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>EDWARD EVERETT</u>		13b. MOTHER'S MAIDEN NAME <u>Madeline Seyb</u>		14. NAME OF HUSBAND OR WIFE <u>not married</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edith M. Daniel</u> ADDRESS <u>5005 Kings Highway</u>				
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain Tumor</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
19a. DATE OF OPERATION <u>5-4-54</u>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		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? <u>287X</u>					
22. I hereby certify that I attended the deceased from <u>5/1</u> , 19 <u>54</u> , to <u>5/9</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>5/9</u> , 19 <u>54</u> , and that death occurred at <u>9:50</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. J. Mohlman, M.D.</u>				23b. ADDRESS <u>St. Louis Children's Hosp</u>		23c. DATE SIGNED <u>5-10-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5/10/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Evangelical Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Donnellson Iowa</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Smith</u> ADDRESS <u>1111 1/2 Popple Ave. Parkersburg</u>	
DATE REC'D BY LOCAL REG. <u>MAY 10 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Smith</u> ADDRESS <u>1111 1/2 Popple Ave. Parkersburg</u>			

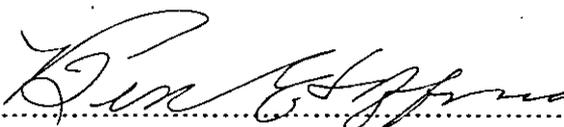
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

---

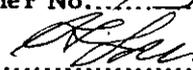
STATEMENT BY LICENSED EMBALMER

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.....  


Licensed Embalmer No. 43

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.