

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14940

FILED APR 22 1957

STATE FILE NUMBER  
3204

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>ST. LOUIS</b> TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St Louis</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>ST. LOUIS CITY HOSP. #1.</b> INSTITUTION		Length of stay in lb <b>226</b>	d. STREET ADDRESS (If outside, give location) <b>1027a Cass ave</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>DALE PRESTON LARSEN</b>			4. DATE OF DEATH <b>APR. 2, 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/9/36</b>
9. AGE (In years last birthday) <b>21</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None at Present</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kenneth Mo</b>
13. FATHER'S NAME <b>Joseph Larsen</b>		14. MOTHER'S MAIDEN NAME <b>Zelma Bernice Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-36-9685</b>	17. INFORMANT <b>Joseph Larsen 1027a Cass ave</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO (b) <b>SUB-ACUTE BACTERIAL ENDOCARDITIS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4300</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>3/29/57</b> to <b>Apr. 2, 1957</b> and last saw her alive on <b>APR. 2, 1957</b> Death occurred at <b>12:15 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Charles E. Hogan, M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>4/2/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/4/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St Louis County</b>
24. FUNERAL DIRECTOR <b>Central Funeral Home 1841 Cass ave</b>		25. DATE RECD. BY LOCAL REG. <b>APR 3 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>

Health, & Welfare Public Service  
S. 300 1-56  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
securing the medical certification in the specific manner required by 193.140 R.S.Mo. 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 W Rister*

Licensed Embalmer No. *3986*

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