

-29587-
STATE FILE NUMBER
7532

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 26 1957

318 Primary Registration District No. 1003

Registration District No. _____ Registrar's No. 7532

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Wayne	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Fairfield <i>§128</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 508 Summit Street.,	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First IRA Middle HENRY Last IRES		Month AUGUST Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal worker		10b. KIND OF BUSINESS OR INDUSTRY Factory	11. BIRTHPLACE (City and state or country) Illinois.
13a. FATHER'S NAME John Ires		13b. MOTHER'S MAIDEN NAME Linnie Hayes	14. NAME OF HUSBAND OR WIFE Helen Ires
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes N.W. 11		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Helen Ires, Fairfield, Illinois.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH 1 WK.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Glomerulonephritis			2 YRS. (?)
DUE TO (c) 1			592X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 WORK <input type="checkbox"/> 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 JULY 22, 1957 to AUGUST 10, 1957 and last saw her/him alive on AUG. 10, 1957 Death occurred at 2:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. O. Vermillion, M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 8/10/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-10-57	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Fairfield, Illinois.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. AUG 12 1957	26. REGISTRAR'S SIGNATURE Carl Smith M.D. <i>mjs</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

OGT 2 1958

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 Stanley H. Dixon Licensed Embalmer No. 4118 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.