

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-003223

JAN 25 1961
AMENDEDRegistration District No. 318 Primary Registration District No. 1003 Registrar's No. 337

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>			Length of stay in 1b <u>3 Days</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2345 Tennessee Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>T.</u> Last <u>IVERSON</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>10</u> Year <u>1961</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/81</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elder Mfg. Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Magdalena M. Iverson</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	17. INFORMANT Address <u>Canterbury Dr.</u> <u>Dr. R. W. Iverson, 7219 bury Dr.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 YEARS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>4200</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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 <u>Aug. 12, 1955</u> to <u>JAN. 10, 1961</u> and last saw her/him alive on <u>JAN. 10, 1961</u> Death occurred at <u>3:06 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>C. C. Kermillion, M.D.</u> (Degree or title)			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>1/10/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1/13/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>		23d. LOCATION (City, town, or country) <u>St. Louis</u>		Mo.	
24. FUNERAL DIRECTOR <u>Drehmann-Harral, 1905 Union Blvd.</u>			25. DATE RECD. BY LOCAL REG. <u>JAN 12 1961</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH

DATE OF DEATH AS REPORTED BY THE

NAME OF DECEASED
RESIDENCE OF DECEASED

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 Warren A. Carver

Licensed Embalmer No. 3534

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.