

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-038864  
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9449

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		a. STATE <u>Ill.</u>	b. COUNTY <u>St. Clair</u>
Length of stay in 1b <u>13 days</u>		c. CITY OR TOWN <u>Washington Park</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>Hamilton Ave. Hamilton Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>2224 N. 53rd St.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>JOHN</u> Last <u>LARSEN</u>			4. DATE OF DEATH Month <u>October</u> Day <u>12</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>9-27-84</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Bergen, Norway</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Nils Larsen</u>		13b. MOTHER'S MAIDEN NAME <u>Methe Ellingsen</u>		14. NAME OF HUSBAND OR WIFE <u>Kathryn Larsen</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W.W.I</u>	16. SOCIAL SECURITY NO. <u>  </u>	17. INFORMANT <u>Mrs. Kathryn Larsen, E. St. Louis, Ill.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <u>Generalized Malignancy of S. U. Tract</u> <u>Original of original lesion unknown</u> Interval between onset and death <u>6 mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (a) <u>  </u> DUE TO (b) <u>  </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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year <u>  </u>
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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 <u>  </u> COUNTY <u>  </u> STATE <u>  </u>
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21. I attended the deceased from <u>Jan 1-'61</u> to <u>Oct 12-'61</u> and last saw him alive on <u>Oct 11-'61</u> <u>Hamilton Nursing Home, St. Louis, Mo.</u> and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>B E Ellis M.D.</u>	22b. ADDRESS <u>546 20 10, East St. Louis, Ill.</u>	22c. DATE SIGNED <u>10-12-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-14-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City, town, or county) <u>Collinsville, Ill.</u>
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24. FUNERAL DIRECTOR <u>John Kassly, East St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 13 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Not Embalmed, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joseph J. Kasly

Licensed Embalmer No. 754

P. O. Address E. W. Jones

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.