

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-030792**

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2223 STATE FILE NUMBER

**FILED JUL 22 1963**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>		a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		c. CITY OR TOWN <u>Webster Groves</u>	
Length of stay in 1b		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>White Oaks Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>414 Selma</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Primus</u> Last <u>Larson</u>			4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-70</u>
9. AGE (last birthday) <u>92</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>Management</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Listing Bureau</u>	11. BIRTHPLACE (City and state or country) <u>Sweden</u>
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>			
13a. FATHER'S NAME <u>Joseph Larson</u>		13b. MOTHER'S MAIDEN NAME <u>Louisa (unknown)</u>	
14. NAME OF HUSBAND OR WIFE <u>-</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Carl Larson RR#1 Pacific Mo</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			<u>10 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)			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
<u>Chronic Lymphogenous leukemia</u>			
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.)	
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>1956</u> to <u>10 July 1963</u> and last saw <u>him</u> live on <u>3 July 1963</u>			
Death occurred at <u>9:10 P 7/10/63</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Hugh R. Waters</u> (Degree or title)		22b. ADDRESS <u>600 Union Blvd. St. Louis</u>	
22c. DATE SIGNED <u>7/11/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>July 13 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kirkwood, Mo</u>
24. FUNERAL DIRECTOR <u>MITTELBERG GERBER</u> ADDRESS <u>COLONIAL CHAPEL</u>		25. DATE RECD. BY LOCAL REG. <u>7-12-63</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy M.D.</u>

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

14003

24007

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USE BLACK INK OR TYPEWRITER RIBBON

**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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis Mo

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.