

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL RECORDS
FILED JUL 1 1946 STANDARD CERTIFICATE OF DEATH

21355

State File No. _____

Registrar's No. 1352

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County Overland St Louis
(b) City or town Overland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME DIANNIE L ERIKSON

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S-O

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: March 29 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 2 22 hr. min.

9. Birthplace: Seattle Washington ~~NDAKOTA~~
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business _____

12. Name Melvin Erickson

13. Birthplace: New England, N. Dakota
(City, town, or county) (State or foreign country)

14. Maiden name Doris Erickson

15. Birthplace: Grand Forks, NDAKOTA
(City, town, or county) (State or foreign country)

16. (a) Informant Melvin Erickson

(b) Address 7724 Brooklyn Court

17. (a) Burial (b) Date thereof: June 25 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethel

18. (a) Signature of funeral director Prosser

(b) Address 784 N Bridge Road

19. (a) 6-24-46 (b) E S McWarren
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Louis County
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 7724 Brooklyn Court
(If rural, give location)
(e) Citizen of foreign country? No
If yes, name country _____

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month June day 21 P.M.
year 1946 hour 10 minute _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: suffocation after being found lying face down on her bed at her home.

Due to: 18252

Due to: 10

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy: Yes

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): Accident 96
(b) Date of occurrence: 6/20/46
(c) Where did injury occur?: Overland, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

While at work? _____ (Specify type of place)
(e) Means of injury: Suffocation
Signature: Arnold J. Willmann Coroner
Clayton, Mo. (Date of death) 6/21/46
Date signed: 6/21/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *W. E. Morris*

Licensed Embalmer No. *3360*

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 this body is not embalmed, fact should be so stated above.