

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42314

State File No. \_\_\_\_\_  
Registrar's No. **10445**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>	c. LENGTH OF STAY (in this place) <b>1 1/2 days</b>	c. CITY OR TOWN <b>Collinsville</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		f. STREET ADDRESS (If rural, give location) <b>819 West Main street. 8120 8</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>IRVIN</b> b. (Middle) <b>R.</b> c. (Last) <b>DETERDING</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>NOVEMBER 14, 1954</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept 20, 1921</b>	9. AGE (In years last birthday) <b>33</b>	IF UNDER 1 YEAR Months Days	IF UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Swift &amp; Co</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Vernon Colorado /</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Lewis Deterding</b>	13b. MOTHER'S MAIDEN NAME <b>Hazel Cain</b>	14. NAME OF HUSBAND OR WIFE <b>Annabelle Deterding</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>	16. SOCIAL SECURITY NO. <b>358-07-9371</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Annabelle Deterding, Collinsville, Ill.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Third ventricular tumor</b> (Type undetermined)		
	ANTECEDENT CAUSES Morbic conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>11/13/54</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>2-7</b>
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22. I hereby certify that I attended the deceased from **NOVEMBER 12 1954**, to **NOVEMBER 14 1954**, that I last saw the deceased alive on **NOV 14, 1954**, and that death occurred at **1:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>C. J. Vermillion, M.D.</b> (Degree or title)	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>11/15/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>11/17/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Collinsville, Illinois</b>
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DATE REC'D BY LOCAL REG. <b>NOV 17 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Herr Funeral Home Collinsville, Ill.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

COLLINSVILLE, ILL.

HERR FUNERAL HOME  
COLLINSVILLE, ILL.

**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 \_\_\_\_\_  
*W. J. Schaefer*

Licensed Embalmer No. 3577

P. O. Address Collinsville, Ill.

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.