

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021737

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5629 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		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</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2503 MINNESOTA</u>		d. STREET ADDRESS (If outside, give location) <u>2503 MINNESOTA</u>	
3. NAME OF DECEASED (Type or print) First <u>OLIVER</u> Middle <u>J</u> Last <u>IFLAND</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1963</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>SEPT. 23, 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICER WORKER MCDONALD AIRCRAFT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>
13a. FATHER'S NAME <u>CHARLES IFLAND</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA WEIN</u>	14. NAME OF HUSBAND OR WIFE <u>LILLIAN IFLAND</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give year or dates of service] <u>YES WORLD WAR 2</u>		17. INFORMANT <u>LILLIAN IFLAND 2503 MINNESOTA</u> Address	
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>Coronary occlusion</u> <u>Myocardial Infarction</u> DUE TO (b) <u>420.1</u> 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			INTERVAL BETWEEN ONSET AND DEATH <u>Spring 1956</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 <u>5:30 A.</u> Month, Day, Year <u>5/27/63</u>		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>5/27/63</u> and last saw her/him alive on <u>5-24-63</u> . Death occurred at <u>5:30 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ralph Berg MD</u> (Degree or title)		22b. ADDRESS <u>3203 S Grand</u>	22c. DATE SIGNED <u>5/27/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>MAY 28, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PARK</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS MO.</u>
25. DATE RECD. BY LOCAL REG. <u>MAY 28 1963</u>		26. REGISTRAR'S SIGNATURE <u>Neal Smith, M.D.</u>	
27. GENERAL DIRECTOR ADDRESS <u>Thomas Kutis 2906 Gravois</u>			

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Graves

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.

*Dr. Regal Berg*