DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

WASHINGTON STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF DEATH

State File No. 237
Registrar's No. 8751

1. PLACE OF DEATH:
(a) County Spokane
(b) City or town Medical Lake Rural (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Eastern State Hospital (If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution Institution (Specify whether)
1 mo., 15 days In this community (Years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington (b) County Kittitas
(c) City or town Ellensburg (If outside city or town limits, write RURAL)
(d) Street No. 12th & Okanogan (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3. (a) FULL NAME Daniel Iverson
3. (b) Was decedent ever a member of the Army, Navy or Marine Corps of the United States? ____ Name of organization in which such service was rendered: ____ Rank ____ Period of service ____
3. (c) Social Security Number ____

4. Sex: Male
5. Color or race: White
6(a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: ?
6(c) Age of husband or wife if alive ____ years
7. Birth date of deceased: ? (Month) ? (Day) 1859 (Year)
8. AGE: Years 84 | Months ? | Days ? | If less than one day ____ hr. ____ min.

9. Birthplace: ? (City, town or county) Minnesota (State or foreign country)
10. Usual occupation: When committed - retired
11. Industry or business: ____
Father 12. Name: Lars Iverson
Father 13. Birthplace: ? (City, town, or county) ? (State or foreign country)
Mother 14. Maiden name: Anna Bitzler
Mother 15. Birthplace: ? (City, town, or county) ? (State or foreign country)

16. (a) Informant's own signature: E. S. Hosp. Records
(b) Address: Medical Lake, Washington
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-9-43 (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director: Kennedy Funeral Home
(b) Address: 2203 W Dean
19. (a) 5-8-43 (Date received local registrar) (b) General Cashey (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month May day 8 year 1943 hour 5: minute 33 p.m.
21. I hereby certify that I attended the deceased from March 23, 1943, to May 8, 1943; that I last saw him alive on May 8, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Terminal bronchopneumonia -	3 days
Cerebral hemorrhage -	10 days
Due to 43 X	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings; Of operations	
Of autopsy (None performed)	

Physician — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature [signature] (M. D. or other)
Address Medical Lake, Wn. Date signed 5/26/43