

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

29608

1. PLACE OF DEATH

County

Registration District No. **701**

Township

Primary Registration District No. **1008**

City **St. Louis** (No. **City Hosp.**)

File No.
Registered No. **8635**
St. Ward

2. FULL NAME

Oliver Carlstrom

(a) Residence, No. **1367^a Temple St. 6** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 5-1891**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40 **3**

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Cleaner & presser**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Kansas City Mo.**

13. NAME **August Carlstrom**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Sweden**

15. MAIDEN NAME **Catherine Miller**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Boonville Mo.**

17. INFORMANT (ADDRESS) **Hospital Information Center Hosp.**

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE **City Hosp. Aug 11 1931**

19. UNDERTAKER (ADDRESS) **City Hosp.**

20. FILED **10 15 31** Registrar

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Aug 8th 1931**

22. I HEREBY CERTIFY, That I attended deceased from **July 1st, 1931, to Aug 8th 1931**
I last saw him alive on **Aug 8th 1931** Death is said to have occurred on the date stated above, at **6:30 P.M.**
The principal cause of death and related causes of importance were as follows:

The principal cause of death and related causes of importance were as follows:
Left lobar pneumonia 8-3-31
106
152B 191
Other contributory causes of importance:
Heat prostration 7-1-31
Cellulitis of rat arm 7-11-31

Name of operation Date of
What test confirmed diagnosis? **Chemical** Was there an autopsy? **Refused**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify
(Signed) **W. Scherman**, M. D.
(Address) **City Hospital**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

