

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.

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

Do not use this space.

OCT 23 1935

30901

1. PLACE OF DEATH

County _____

Registration District No. _____

791

Township _____

Primary Registration District No. _____

1003

City _____ (No. _____)

File No. _____

Registered No. _____

8295-
St. _____ Ward _____

Walter Shostrand

2. FULL NAME

(a) Residence, No. _____
(Usual place of abode)

1035 Carroll St. Ward 23

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 11, 1935*

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

22. I HEREBY CERTIFY, That I attended deceased from *8/24* 19*35* to *Sept 11, 1935*

I last saw him alive on *Sept 11, 1935*. Death is said to have occurred on the date stated above, at *6:30* a.m.
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 9 - 1934*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, or min. *0 10 2*

Date of onset

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *none*

acute dysentery
(Hiss-Russell)

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 _____

Other contributory causes of importance: *136*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis, Mo*

13. NAME *Edward Shostrand*

Name of operation _____ Date of _____

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

What test confirmed diagnosis? _____ Was there an autopsy? _____

15. MAIDEN NAME *Blanche Culwell*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Minnesota*

Where did injury occur? _____ (Specify city or town, county, and State)

17. INFORMANT *Joseph J. Kest*

Specify whether injury occurred in industry, in home, or in public place. _____

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Matthews* DATE *Oct 10, 1935*

Manner of injury _____

19. UNDERTAKER *Heck Bros. Mfg. Co.*

Nature of injury _____

(ADDRESS) *201 50 1/2 West 10th St.*

24. Was disease or injury in any way related to occupation of deceased? _____

20. FILED *SEP 1-2 1935*

If so, specify *Sept 11, 1935*

(ADDRESS) *St. Louis, Mo.*

(Signed) *Joseph J. Kest*

Registrar. *J. Bredeck*

(Address) *City Hoop # 9*

