

No. 2
11-10-39
5-1
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

16989

State File No.

Registrar's No.

4467

JUN 15 1940
791
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2014 S. 11th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 4 5/8 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")
(d) Street No. 2014 S. 11th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18th
year 1940 hour 4:30 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Primary Occlusion
Due to: Arteriosclerosis
Due to: Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____

Duration

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? _____

While at work _____ (Specify type of place) _____
_____ (b) Means of injury _____

28. Signature [Signature] (M. D. or other) _____
Address [Address] Date Signed _____

3. (a) PRINT FULL NAME JOHN CARLIN L. 45

8. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Budget Carlson 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Feb 8 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 3 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Bellevue, Ind (City, town, or county) (State or foreign country)

10. Usual occupation Molder

11. Industry or business St. Louis Steel

12. Name Michael Carlson

13. Birthplace Ireland (City, town, or county) (State or foreign country)

14. Maiden name Elyzabeth Peas (State or foreign country)

15. Birthplace Berlin (City, town, or county) (State or foreign country)

16. (a) Informant Gather Meyer

(b) Address 3819 Vista Ave

17. (a) _____ (b) Date thereof 5-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galaxy Center

18. (a) Signature of funeral director John G. Galbraith

(b) Address 928 W. Grand Blvd

19. (a) MAY 20 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed

Guy W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address

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 this body is not embalmed, above space should be left blank.