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FILED MAR 25 1941 791

Primary Registration District No. **1003**

Registrar's No. **1489**

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

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Lukes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 DAYS
(Specify whether years, months or days)

In this community 7 Days

3. (a) PRINT FULL NAME William F. Carlson

3. (b) If veteran, name war No

3. (c) Social Security No Don't Know

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan., 11, 1907
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>34</u>	<u>1</u>	<u>3</u>	hr. _____ min. _____

9. Birthplace Las Animas Colo
(City, town, or county) (State or foreign country)

10. Usual occupation US Mail Carrier

11. Industry or business Veterans Administration

12. Name Charles A. Carlson

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

14. Maiden name Hilma North

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

16. (a) Informant Hilma Carlson

(b) Address Las Animas Colo

17. (a) Removal (b) Date thereof 2-14-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Las Animas

18. (a) Signature of funeral director Powell Funeral Home

(b) Address Las Animas Colo

19. FEB 15 1941 (b) J. F. Bredich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Colorado (b) County 999

(c) City or town FT WYON
(If outside city or town limits, write "RURAL")

(d) Street No. Veterans Hospital
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
year 1941 hour 7:15 minute _____ A.M.

21. I hereby certify that I attended the deceased from 2-6-41, 19____, to 2-14-41, 19____;
that I last saw him alive on 2-14-41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Acute edema of lungs
Post-embolic Pulmonary

Due to Pulmonary Embolism

Due to _____

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

Major findings: Post-Embolic Pulmonary

Of operations _____

Of autopsy Examined

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) (e) Means of injury.

23. Signature J. F. Bredich (M. D. or other) _____

Address 320 North 10th Date signed 2-14-41

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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 *Heward M. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *Thomas M...*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 52417
Registrar's No. 1489

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Lukes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Da (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME William F. Carlson
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____ month _____ day _____

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

NEEDLE CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14 - 41
year _____ hour _____ minute _____ M.

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

Immediate cause of death _____

Due to acute edema of lungs - post encephalitic residual paralysis agitans

Due to By query - 27 B -

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

Major findings: Infectious encephalitis

Of operations _____

Of autopsy _____

Duration _____

3 11

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) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

