

S. No. 2
M-5-42
7-5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8350

State File No. _____
Registrar's No. 2517

FILED MAR 20 1943 18

Registration District No. _____ Primary Registration District No. 1003

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

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:
St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 324 Laurel St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Edith Adelaide Hallstrom
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar. day 14
year 1943 hour 7 minute 30 A.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Thomas W. Hallstrom 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 25 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 25 1942 to March 14 1943;
that I last saw her alive on March 13 1943;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
54 3 19 hr. min.

Immediate cause of death Cerebral hemorrhage Duration 6 mo

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

Due to General atherosclerosis 3 year

10. Usual occupation Housewife
11. Industry or business _____
12. Name Fred J. Swain
13. Birthplace England 4
(City, town, or county) (State or foreign country)
14. Maiden name Louise Avison
15. Birthplace England 4
(City, town, or county) (State or foreign country)

Due to _____
Other conditions (Include pregnancy within 3 months of death) 0 2

16. (a) Informant Mrs. Louise Thomas
(b) Address 5900 McPherson Ave.
17. (a) Burial (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cem.
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) MAR 16 1943 (b) J. F. Prodeck
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____
Of autopsy _____
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 Arthur B. Way (M. D. or other) 0
Address 3220 Washington Ave Date signed 3-16-43

3720 Westchester
13-430 Morris
1-3 - Jones

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 Robert M. Sanford
Licensed Embalmer No. 2273
P. O. Address Thames

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.