

FILED MAY 7 1943 318

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 3986

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:  
City Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3yr. 1mo. 23days  
(Specify whether years, months or days) unknown

3. (a) PRINT FULL NAME Charles Anderson

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 03

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

7. Birth date of deceased. March 17 1864  
(Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days 20 If less than one day ..... hr. .... min.

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

10. Usual occupation. nil

11. Industry or business. unknown

12. Name. unknown

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

14. Maiden name. unknown

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

16. (a) Informant. Hiram Bazzoli  
(b) Address. 5800 Arsenal

17. (a) Automob. Blood (b) Date thereof 4-10-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, D.C.

18. (a) Signature of funeral director. W. Richter  
(b) Address. 2890 Ridge St

19. (a) APR 25 1943 (b) J. J. Probst  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.  
(If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No)  
If yes, name country Sweden

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1943 hour 9 minute 0 P. M.

21. I hereby certify that I attended the deceased from April 1 1943 to April 7 1943 that I last saw h. alive on April 7 1943 and that death occurred on the date and hour stated above.

Immediate cause of death. Degenerative Heart Disease Duration yes

Due to Generalized Arteriosclerosis

Due to Senility

Other conditions. (Include pregnancy within 3 months of death) 93

Major findings: Of operations. 93

Of autopsy. 93

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. J. Probst (M. D. or other) MD  
Address. City Infirmary Date signed. 4/7/43

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

MOTHER FATHER

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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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.....

Licensed Embalmer No.....

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, fact should be so stated above.**