

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15287

State File No. _____

Registrar's No. 1056

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

FILED MAY 15 1943

Registration District No. _____

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2401 Keilen Ave.,
(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 St. Louis
(c) City or town Wellston
(If outside city or town limits, write "RURAL")
(d) Street No. 2401 Keilen Ave.,
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Augusta Backlund.

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife Charles J. Backlund 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 19, 1855.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 4 13 _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____
12. Name August Backlund
13. Birthplace Sweden
(City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Laura Sauerwein
(b) Address 2401 Keilen Ave.,

17. (a) Burial (b) Date thereof May 4/43.
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cem.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

19. (a) MAY 4 - 1943 (b) E. D. McKinnon
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
year 1943 hour 3.30 minute A.M. M.

21. I hereby certify that I attended the deceased from June 30 1942 to May 2 1943.
that I last saw h. ER alive on May 1st 1943.
and that death occurred on the date and hour stated above.

Immediate cause of death Chc. Myocarditis
Several years.

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

PHYSICIAN
Major findings:
Of operations 93d
Of autopsy _____
Underline the cause to which death should be charged statistically.

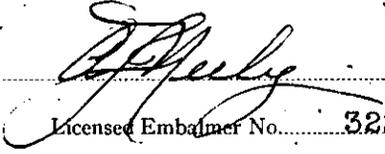
22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Dr. [unclear] (M. D. or other) DO.
Address 6201 [unclear] Date signed 5-5-43

Dr. ~~Ed~~ Hicks
6201 Lotus Ave.,
MU. 1650.

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..... 3225

P. O. Address..... 1125 Hodiamont Ave.,

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.