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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 6 1943

Registration District No. 217

Primary Registration District No. 3063

Registrar's No. 1041

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County 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 St. Louis
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. 415 Erber
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Della Catherine Johnsen

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thorvald Johnsen 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Dec 4 1900
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 4 25 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name William H. Wessel
13. Birthplace Gordenville, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Emma Sievers
15. Birthplace Tilsit, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr/ Thorvald Johnsen
(b) Address 415 Erber, Kirkwood, Mo.,
17. (a) Burial (b) Date thereof 5-1-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cem.

18. (a) Signature of funeral director Louis H. Bopp Inc.
(b) Address Kirkwood, Mo.
19. (a) 5-3-43 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th,
year 1943 hour 2:AM minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to April 28, 1943
that I last saw her alive on April 28, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 10 Hours

Due to Hyperextension (Lifting)
Due to _____

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

Major findings: None PHYSICIAN _____
Of operations _____
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)
(c) Means of Injury _____
23. Signature [Signature] (M. D. or other) M.D.
Address [Address] Date signed _____

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

MOTHER FATHER

MAY 13 1948

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.