

FILED JUN 1943  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

16715

State File No.

Registrar's No.

3366

FILED JUN 1943  
Registration District No. 318

Primary Registration District No.

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. Anthony's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles Wallerstedt

3. (b) If veteran, name war None  
3. (c) Social Security No. 488-05-0385

4. Sex Male 5. Color or Race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna V. Wallerstedt  
6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased Feb 24 1906  
(Month) (Day) (Year)

8. AGE: Years 37 Months 2 Days 6  
If less than one day hr. min.

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

10. Usual occupation Supervisor

11. Industry or business

12. Name Charles Wallerstedt

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

14. Maiden name Elizabeth Mueller

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

16. (a) Informant Anna V. Wallerstedt

(b) Address 4953a Holly Hills Ave

17. (a) Burial (b) Date thereof 4-12-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Paul

18. (a) Signature of funeral director Kriegshauser Mortuaries

(b) Address 4228 So. Kingshighway Blvd.

19. (a) APP (b) J. T. Brudick  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4953a Holly Hills Ave.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8th  
year 1943 hour 9:15 minute A.M. M.

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

Immediate cause of death Duration

Due to Suffering of Brain  
Cause undetermined  
Due to  
Other conditions (Include pregnancy within 3 months of death)

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) Means of injury

23. Signature Alfred J. Perry (M. D. or other)

Address 11111 1st St. Date signed 4/12/43

**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.....

*Reinhold F. Lohmann*

Licensed Embalmer No. 3395

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19431

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 3366

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Anthony's 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)

3. (a) PRINT FULL NAME Charles Wallerstedt

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

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased Feb. 2nd 1906  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
37 2 6 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) JUN 10 1944 (b) J. F. Bredsch  
(Date received and registered) (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8th  
year 1943 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 \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

16715