

FILED MAR 20 1944
Registration District No. **318**

Primary Registration District No. **1002**

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:
1607 Ohio Av. 1
(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)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **000**

(c) City or town **ST. LOUIS** (If outside city or town limits, write "RURAL") **173**

(d) Street No. **1607 Ohio Av.** (If rural, give location) **923**

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country **0**

3. (a) PRINT FULL NAME **HILMA AMELIA WALLERSTEDT**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NO**

4. Sex **FEMALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **NILS WALLERSTEDT**

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

7. Birth date of deceased **NOVEMBER 26 1859**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **6** year **1944** hour **1** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Feb 13** 19 **44** to **Mar. 6** 19 **44** and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
84	3	9	hr. _____ min. _____

Immediate cause of death **Intra-abdominal hemorrhage** Duration **12 hours**

Due to **Hypertensive heart disease** years _____

Due to **arteriosclerosis** years _____

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

9. Birthplace **SWEDEN 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **NIL**

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name **ANDREW LINDSTROM**

13. Birthplace **SWEDEN 4**
(City, town, or county) (State or foreign country)

14. Maiden name **HELENA BENZAY**

15. Birthplace **SWEDEN 4**
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **Mrs. Ethel Locher**

(b) Address **1607 Ohio Av.**

17. (a) **BURIAL** (Burial, cremation, or removal)

(b) Date thereof **MARCH 9-44** (Month) (Day) (Year)

(c) Place: burial or cremation **NEW ST. MARCUS CEM**

While at work? _____ (Specify type of place)

(e) Means of injury **0**

23. Signature **Dr. A. Seib** (M. D. or other) **md**

Address **2323 Lafayette Ave** Date signed **3/11/44**

18. (a) Signature of funeral director **E. J. Schner**

(b) Address **3125 Lafayette Ave**

19. (a) **MAR 8 1944** (Date received local registrar)

(b) **J. F. Busch** (Registrar's signature)

84K

St Louis

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.....

Joseph Bollmer

Licensed Embalmer No. *4014*

P. O. Address *St Louis mo*

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.