DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 5 1946

State File No. 39595

Registration District No. 318 1003

Primary Registration District No.

Registrar's No. 11198

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1940 a Louisiana
(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 Missouri (b) County

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

(d) Street No. 1940 a Louisiana
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Erik Nilsen

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Josephine Nilsen

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

7. Birth date of deceased Sept. (Month) 21. (Day) 1864 (Year)

8. AGE: Years 81 Months 2 Days 28 If less than one day hr. min.

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

10. Usual occupation Railroad Clerk, retired.

11. Industry or business

FATHER
12. Name Erik Niels
13. Birthplace Sweden (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Mary Erikson
15. Birthplace Sweden (City, town, or county) 4 (State or foreign country)

16. (a) Informant Edgar L. Witt
(b) Address 2929 S. Jefferson

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director Witt Bros. L. & M. Co.
(b) Address 2929 S. Jefferson

19. (a) DEC 21 1945 (Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19 year 1945 hour 2 minute 30 A.M.

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

Duration

Immediate cause of death Coronary Thrombosis

Due to

Due to 94a

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed 12/21/45

(Licensed Embalmer's Statement on Reverse Side)

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 me, Registered Apprentice No. , working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 2929 So. Jefferson

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.

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STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1198

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

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: —
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo - (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

3. (a) PRINT FULL NAME Erik Nilsen

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 wd

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 21 (Day) 1864 (Year)

8. AGE: Years 81 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

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

19. (a) Dec 21-1945 (Date received local registrar) (b) J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 2 19 year 1945 hour minute M.

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

Immediate cause of death — Duration

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.

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(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

CAIU — 7 1970

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