

FILED FEB 11 1946

Registration District No. 577

Primary Registration District No. 3069

Registrar's No. 277

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Richmond Heights  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Mary's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1-day  
 (Specify whether in this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County 000  
 (c) City or town St. Louis 17  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5944 Etzel Ave. 9  
 (If rural, give location) 1  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ben A. Jostrand  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Jan. day 30th.,  
 year 1946 hour 3 minute p. M.

4. Sex M.O. 5. Color or race W.  
 6. (a) Single, widowed, married, divorced W.  
 6. (b) Name of husband or wife Alice Jostrand  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Aug. 15th., 1870  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2/15/38, 19\_\_\_\_ to 1/30/46, 19\_\_\_\_  
 that I last saw h. alive on 1/30/46, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
75 5 15 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma lung Duration 6 mo.  
 Due to H7 dl

9. Birthplace St. Louis Mo. 0  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Pres. St. Louis Stair Co.

Other conditions Diabetes 7 yr  
 (Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
 12. Name Ben Jostrand  
 13. Birthplace France 5  
 (City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace 9  
 (City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Frank J. Jostrand  
 (b) Address 5944 Etzel Ave.  
 17. (a) Burial (b) Date thereof 2-2-46  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary

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? \_\_\_\_\_

18. (a) Signature of funeral director Arthur J. Kennelly  
 (b) Address 3840 Lindell Blvd.  
 19. (a) 0-4-46 (b) E. S. McFarland  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
 23. Signature W. J. Faeh (M. D. or other) med  
 Address Number 100 1/2 E. 10th St. Date signed \_\_\_\_\_

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

2011

MAR 18 1946

Handwritten: 1-3  
Staley Marshall  
AM

DF: O. L. ...

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lundell

**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.**