S. No. 2
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v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1947

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 37631

Primary Registration District No.

Registrar's No. 147

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

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Washington Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Francis
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1/2 Dr. (Specify whether
In this community 32 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Franklin
(c) City or town Washington (If outside city or town limits, write "RURAL")
(d) Street No. 115 Stafford (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country none

3. (a) PRINT FULL NAME GUSTAV WAHLSTROM

3. (b) If veteran, name war no

3. (c) Social Security No. 492-10-5641

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Marie Wahlstrom

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased June (Month) 6 (Day) 1879 (Year)

8. AGE: Years 68 | Months 5 | Days 6 | If less than one day — hr. — min.

9. Birthplace (not known) (City, town, or county) Sweden (State or foreign country)

10. Usual occupation Barber

11. Industry or business

FATHER
12. Name Not known.
13. Birthplace (City, town, or county) Sweden (State or foreign country)

MOTHER
14. Maiden name Not known
15. Birthplace (City, town, or county) Sweden (State or foreign country)

16. (a) Informant Mrs. Gustav Wahlstrom
(b) Address Washington.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15-47 (Month) (Day) (Year)
(c) Place: burial or cremation Burial at Washington

18. (a) Signature of funeral director Otto & Co.
(b) Address Washington Mo.

19. (a) NOV 15 1947 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 12
year 1947 hour 9: minute 15 P. M.

21. I hereby certify that I attended the deceased from Feb 8, 1946 to Nov 12, 1947
that I last saw him alive on Nov 12, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Congestive heart failure	Duration
Due to Carcinoma of liver + myocarditis	
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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature [illegible] (M. D. or other)
Address Washington Mo Date signed 11-14-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number ------------------------
Date Filed ---------- 11-18-47 ----------

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 ....
Maurice H. Wellenbrink ...., Registered Apprentice No. 442,
working under my personal supervision.

Signed [illegible signature]

Licensed Embalmer No. 2464

P. O. Address Washington 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.