

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37631**

FILED NOV 19 1947

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

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

Registrar's No. **147**

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 of location) **0**  
(d) Length of stay: In hospital or institution **1 1/2 hr** (Specify whether  
In this community **32 yrs** years, months or days)

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 **Maria Wahlstrom** 6. (c) Age of husband or wife if alive **25** years  
7. Birth date of deceased **June 6-1879** (Month) (Day) (Year)

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

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

10. Usual occupation **Barber**

11. Industry or business

12. Name **Not known**  
13. Birthplace **Sweden** (City, town, or county) (State or foreign country)  
14. Maiden name **Not known**  
15. Birthplace **Sweden** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Gustav Wahlstrom**  
(b) Address **Washington**  
17. (a) **Burial** Date thereof **Nov 15-47** (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Burial at Washington**

18. (a) Signature of funeral director **Wahlstrom**  
(b) Address **Washington Mo.**  
19. (a) **NOV 15 1947** (Date received local registrar) (b) Registrar's signature

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. **118 Stafford** (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **12** year **1947** hour **9:** minute **18 P.M.**

21. I hereby certify that I attended the deceased from **Feb 8** 19**46** to **Nov 12** 19**47**  
that I last saw him alive on **Nov 12** 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive heart failure** Duration  
**Coronary arteries + myocardium**

Due to **Coronary arteries + myocardium**  
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 **0**

23. Signature **Wahlstrom** (M. D. or other) **MD**  
Address **Washington Mo.** Date signed **11-14-47**

(Licensed Embalmer's Statement on Reverse Side)

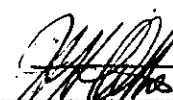
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Marcia H. Wellenbach, Registered Apprentice No. 442  
working under my personal supervision.

Signed 

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.