

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20616**

FILED JUN 30 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **546** Registrar's No. **1300**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Overland</b>		c. CITY OR TOWN <b>Maryland Heights</b> d. RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. LENGTH OF STAY (In this place) <b>3 weeks</b>		f. STREET ADDRESS (If rural, give location) <b>R#1 Box # 661</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Shepard Nursing Home</b>			

3. NAME OF DECEASED (Type or Print) <b>Gustav August Persson</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 6, 1955</b>		
a. (First)		b. (Middle)		c. (Last)	

5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Nov. 22, 1878</b>		9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Wagner Elec. Corp</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>New Minden, Ill.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
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13a. FATHER'S NAME <b>Charles Persson</b>			13b. MOTHER'S MAIDEN NAME <b>Margaret Twenhafel</b>			14. NAME OF HUSBAND OR WIFE <b>Lydia Persson</b>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>493-10-1753</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Lydia Persson Maryland Heights, Mo.</b>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Retention myocardial infarction, days</b> ANTECEDENT CAUSES <b>Cerebral thrombosis - 3 days</b> DUE TO (b) <b>Anterograde</b> DUE TO (c) <b>years</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebral thrombosis</b> <b>3 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4201</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5-15, 1955**, to **6-5, 1955**, that I last saw the deceased alive on **6-3, 1955**, and that death occurred at **8:08 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Marvin Roseman</b>		23b. ADDRESS <b>Overland Med Center</b>		23c. DATE SIGNED <b>6-6-55</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-9-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Trinity Luth. Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Nashville, Ill. via Motor</b>	
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DATE REC'D BY LOCAL REG. <b>6/7/55</b>		REGISTRAR'S SIGNATURE <b>Herbert R. Danke M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Baumman Bros Inc 2504 Woodson Rd-Overland-14-Mo.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *David C. Gibson*

Licensed Embalmer No. *340*

P. O. Address *Overland*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.