

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 9 - 1957

41703

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

11073

Registrar No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Jennings 4138	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS 9406 Westchester Dr	
Length of stay in hospital 8 Hrs.		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

3. NAME OF DECEASED (Type or print) First Marie Middle Louise Last Backlund			4. DATE OF DEATH Month 11 Day 17 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/1869	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Sweden	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gustafson			14. MOTHER'S MAIDEN NAME -		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Arthur Backlund 9406 Westchester Dr.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 1 DAY
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUODENAL ULCER		
DUE TO (c) 541.0		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **OCT. 4, 1957** to **NOV. 17, 1957** and last saw her ^{alive} **alive on NOV. 17, 1957**
Death occurred at **7:15 A. m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Theodore J. Rupp, Jr., M.D. (Degree or title)	22b. ADDRESS 9311 DUENKE DR. ST. LOUIS COI 15, MO.	22c. DATE SIGNED 11/19/1957
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/20/57	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County Mo.		

24. FUNERAL DIRECTOR Drehmann-Harral	ADDRESS 1905 Union Blvd.	25. DATE RECD. BY LOCAL REG. NOV 19 1957	26. REGISTRAR'S SIGNATURE Carl Smith M.D.
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(Licensed Embalmer's Statement on Reverse Side)

Securing the medical certificate in the same manner required by 193.140 MoRS 1949.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56

Dr. Theodore J. Repp Jr.
9300 Highway 67
Un 8-3800
Hrs. 2-5 Monday
10-1 Tuesday

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 *Albert R. Thompson*

Licensed Embalmer No. *423*

P. O. Address *St. Joe*

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.