

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003902
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 319

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Will		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Valley Park		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Joliet		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Moll Nursing Home		Length of stay in lb 8 mo.	d. STREET ADDRESS (If outside, give location) 300 Harwood St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Augusta Middle Bernadine Last Carlson			4. DATE OF DEATH Month February Day 1 Year 1959		
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 Aug. 17, 1866	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Unknown Liljegren		13b. MOTHER'S MAIDEN NAME Bernadine Unknown		14. NAME OF HUSBAND OR WIFE William Carlson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. E.H. Patrick, #2 Hardith Hill		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral 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) Generalized arteriosclerosis					3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 351K					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 6-12-58 , to 2-1-59 and last saw ^{her} alive on 1-31-59 Death occurred at 11:20 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>W. H. Sheslie</i> (Degree or title)			22b. ADDRESS Kirkwood 12 Mo		22c. DATE SIGNED 2/2/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-2-59	23c. NAME OF CEMETERY OR CREMATORY Elm Hurst Cemetery		23d. LOCATION (City, town, or county) (State) Joliet, Ill.	
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. 2-2-59	26. REGISTRAR'S SIGNATURE <i>John C. Murphy, M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no related. All diseases in Part I must be causally related.

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 *Robert M. Murray*
Licensed Embalmer No. *37490*
P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. --
If this body is not embalmed, fact should be so stated above.