

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014785

STATE FILE NUMBER

FILED MAY 6 1959

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

2 3927

300
1-57
3
93
03

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>5202 ITASKA</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ERIK</u> Middle <u>C. J.</u> Last <u>CARLSON</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>19</u> Year <u>1959</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 11, 1883</u>
9a. AGE (In years last birthday) <u>75</u>		9b. UNDER 1 YEAR Months _____ Days _____	9c. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>SWEDEN</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>NOT KNOWN</u>	
13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MARY L.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>492-24-3979</u>	17. INFORMANT Address <u>MARY L CARLSON 5202 ITASKA</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction & Abdominal Aneurysm</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Feb. 5, 1959</u> <u>& 12 hours</u> <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Chronic Nephritis</u>			<u>592x</u> ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiovascular Accident - April 11, 1959</u>			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 _____ o.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 <u>2/5/59</u> to <u>4/19/59</u> and last saw him alive on <u>4/19/59</u> Death occurred at <u>11:10 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>FR Bradley</u> M. D.		22b. ADDRESS <u>BARNES HOSPITAL</u>	
22c. DATE SIGNED <u>4/19/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>4/22/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CREMATORY</u>
23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>			
24. FUNERAL DIRECTOR <u>J L ZIEGENHEIN & SONS</u>		25. DATE RECD. BY LOCAL REG. <u>7027 GRAYVOIS APR 21 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u> <u>m. & B.</u>

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 *Donald E. Bering*

Licensed Embalmer No. *4863*

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.