

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If outside, give location) 7048 Nashville Ave.	

3. NAME OF DECEASED (Type or print) First Middle Last GOSTA M. NILSSON			4. DATE OF DEATH Month Day Year Nov. 4 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1894	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Regional Ser. Mgr.-Westinhouse Electric Co.		10b. KIND OF BUSINESS OR INDUSTRY Sweden	11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Augustus Nilsson	13b. MOTHER'S MAIDEN NAME Mathilda Johnsen	14. NAME OF HUSBAND OR WIFE Mabel M. Nilsson
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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) Yes World War I	16. SOCIAL SECURITY NO.	17. INFORMANT Mabel M. Nilsson 7048 Nashville Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Cerebral Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH 5 hrs
DUE TO (b) <i>Myocardial infarction (acute) with rupture - massive hemorrhage</i>		24 hrs
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 451x	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from 10/8/60 to 11/4/60 and last saw her/him alive on 11/4/60 Death occurred at 11:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Dr. [Signature]</i>	(Degree or title)	22b. ADDRESS 50 Maryland Plaza	22c. DATE SIGNED 11/7/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov. 8, 1960	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Kriegshausen 9450 Olive St. Road	25. DATE RECD. BY LOCAL REG. NOV 7 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Edwin A. McRee

Licensed Embalmer No. 3029

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.