MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6759

File No. .....

Registered No. 1590

1. PLACE OF DEATH

County .....

Township .....

City St. Louis (No. City Hospital .....St. .....Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME John Carlson

(a) Residence. No. 1447 (Usual place of abode) 749 A 3 St., 22 Ward. .....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nor Kunn

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
abt	76			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....

(STATE OR COUNTRY) Sweden

PARENTS

10. NAME OF FATHER Carl Lued Carlson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....

(STATE OR COUNTRY) Sweden

12. MAIDEN NAME OF MOTHER Nor Kunn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....

(STATE OR COUNTRY) Sweden

14. INFORMANT Hospital Information

(Address) City Hospital

15. FILED FEB 28 1927 Mark Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 3 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to Feb 3, 1927, that I last saw him alive on Feb 3, 1927, and that death occurred, on the date stated above, at 12 20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. myocarditis

936

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) D. L. Magnus, M. D

2/3, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Louis C. | DATE OF BURIAL 2/19 1927

20. UNDERTAKER W. Richter | ADDRESS 3500 Rutger

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Carlson