

Registration District No. **791** Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH: **1003** **RECD SEP 14 1939**
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Jewish Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days** (Specify whether _____)
In this community **46 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **1**
(c) City or town **St. Louis** **16**
(If outside city or town limits, write "RURAL")
(d) Street No. **3915 Fairview**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **46 years** years.

3. (a) PRINT FULL NAME **Mrs. Sophia Carlson 642**
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Oscar Carlson** 6. (c) Age of husband or wife if alive **69** years
7. Birth date of deceased **August 24 1869** (Month) (Day) (Year)

8. AGE: **69** Years **11** Months **9** Days If less than one day _____ hr. _____ min.

9. Birthplace **Falkenberg Sweden**
(City, town, or county) (State or foreign country)

10. Usual occupation **Household**

11. Industry or business _____

MOTHER FATHER
12. Name **Bengt Carlson**
13. Birthplace **Sweden**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. Irene Ross**
(b) Address **3657a Dunnica**

17. (a) **Burial** (b) Date thereof **August 4, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Concordia Cemetery**

18. (a) Signature of funeral director **Benderweidner**
(b) Address **1936 St. Louis Avenue**

19. (a) **8-3-39** (b) **J. B. Budnick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **2nd** year **1939** hour **12** minute **30** A. M.
21. I hereby certify that I attended the deceased from **April 23 1939** to _____ 19____;
that I last saw her alive on **Aug 1st** 19**39** and that death occurred on the date and hour stated above.

Immediate cause of death **Pseudo bulbar Paralysis**
Due to **Degenerative Atrophic leuk disease - Cerebral Atrophic Leukosis**
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy **performed Jewish hospital**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work _____ (f) Means of injury _____
23. Signature **Dr. Herman J. Rosupfeld** (M. D. or other)
Address **601 Katy, St. Louis** Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Felix J. Krupin*
Licensed Embalmer No. *3497*
P. O. Address *1936 St. Louis*

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 this body is not embalmed, above space should be left blank.