

42053

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 11176

JAN 12 1934 791
Registration District No. 7000

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County 2
(b) City or town St. Louis
(c) Name of hospital or institution:
3745 Lincoln Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")
(d) Street No. 3745 Lincoln Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A? 58 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 28
year 1939 hour 12:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from 11 45 AM, 1939, to 12 PM 12/28/39
that I last saw him alive on 12/28, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cerebral embolus 5
Due to chemic embolus minutes
3 yrs.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature John J. Smith (M. D. or other) MS
Address 3635 N. Huntington Date signed 12/28/39

3. (a) PRINT FULL NAME Edward Dahl 400

3. (b) If veteran, name war None 3. (c) Social Security No. 498-09-5190

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ida Dahl 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Dec 21 1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Stock Clerk

11. Industry or business International Shoe Co

12. Name Peter Dahl

13. Birthplace Sweden

14. Maiden name Maria Johnson
(City, town, or county) (State or foreign country)

15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Ida Dahl

(b) Address 3745 Lincoln Ave

17. (a) Burial (b) Date thereof January 1 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Petz Brothers

(b) Address 3029 Lafayette Ave

19. (a) DEC 29 1939 (b) _____
(Date received local registrar)

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.

*Dr. Frederick
3635 N. Newmead
Mun-3534*

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 *Francis Owens*
Licensed Embalmer No. *2245*

P. O. Address.....

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.