

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7991**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(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: **St. Louis City Hospital #1,**
(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 _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
 (c) City or town **St. Louis** **11**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1515 N. Spring Ave**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Axel Wilson**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Mathilda Wilson** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **Mar 2, 1867**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	6	19	hr. _____ min. _____

9. Birthplace **Sweden** **7**
(City, town, or county) (State or foreign country)

10. Usual occupation **Yard man** **7**

11. Industry or business _____ **7**

12. Name **Axel Wilson** **7**

13. Birthplace **Sweden** **7**
(City, town, or county) (State or foreign country)

14. Maiden name **Mathilda**

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

16. (a) Informant **Mathilda Wilson**

(b) Address **1515 N. Spring Ave**

17. (a) **Burial** (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lafayette Park**

18. (a) Signature of funeral director **J. W. Egan**

(b) Address **1389 N. Grand**

19. (a) **SEP 25 1940** (b) _____
(Date of registration) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **22**,
 year **1940** hour **7:45** minute _____ P. M.

21. I hereby certify that I attended the deceased from **September 20**, 19 **40**,
 that I last saw him alive on **September 22**, 19 **40**,
 and that death occurred on the date and hour stated above.

Immediate cause of death **cardiac hypertrophy & chronic myocarditis** **U**
Duration

Due to _____

Due to _____

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 **J. W. Egan** (M. D. or other) _____

Address **1515 Lafayette Ave.** Date signed **9/23/40**

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 BWF
Licensed Embalmer No. 1591
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, fact should be so stated above.