

No. 2
4-13-40
5-17-39
I X23159

FILLED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **9376**
Registrar's No. **2786**

791

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: **St. Louis.**
(a) County _____
(b) City or town **St. Louis, Mo.**
(c) Name of hospital or institution: **City Infirmary. 9**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **September 12, 1940**
In this community **25 yrs.**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED: **000**
(a) State **Mo.** (b) County **St. Louis.**
(c) City or town **St. Louis. 13**
(If outside city or town limits, write "RURAL")
5800 Arsenal St.
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? **Foreigner.** years.

3. (a) PRINT FULL NAME **Charles Carlstrom**

MEDICAL CERTIFICATION

3. (b) If veteran, **Cannot say** name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH: Month **March** day **22,**
year **1941.** hour **1:10** minute _____ p. M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced / **Separate**
6. (b) Name of husband or wife **Hattie Jensen**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **January 4, 1861**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **September 12,** 19 **40** to **March 22,** 19 **41**
that I last saw him alive on **March 22,** 19 **41**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
80 **2** **18** _____ hr. _____ min.

Immediate cause of death
Cardiac decompensation

9. Birthplace **Sweden. 4 Foreigner**
(City, town, or county) (State or foreign country)

Due to **Degenerative heart disease**

10. Usual occupation **Carpenter;**
11. Industry or business **X**

Due to _____

MOTHER FATHER { 12. Name **Oscar Carlstrom**
13. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)
14. Maiden name **Louise Holstrom**
15. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
9307

16. (a) Informant **E. Molony**
(b) Address **5800 Arsenal St.**

Major findings: Of operations _____
Of autopsy **1318**

17. (a) **Cremation** (b) Date thereof **3-29-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **City Crematory**

PHYSICIAN

18. (a) Signature of funeral director **J. J. Ryan**
(b) Address **City Crematory**
19. (a) **MAR 29 1941** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

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)
(a) Means of injury **D**

23. Signature **Robert E. Shank** (M. D. or other)
Address **5800 Arsenal** Date signed **3/28/41**

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

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.....

Licensed Embalmer No.....

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.