

FILED NOV 12 1948

Registration District No. **318**

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. **1003**State File No. **34105**Registrar's No. **9518**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Baptist Hospital
 (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

3. (a) PRINT FULL NAME Gosta Ericson

3. (b) If veteran, name war No 3. (c) Social Security No. Unknown

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

6. (b) Name of husband or wife Esther K. Ericson 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased January 23 1902
 (Month) (Day) (Year)

8. AGE: Years 46 Months 9 Days 8 If less than one day hr. _____ min. _____

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

10. Usual occupation Baker11. Industry or business Bakery12. Name A. L. Erickson

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

14. Maiden name Anna Julin
 15. Birthplace Sweden
 (City, town, or county) (State or foreign country)

16. (a) Informant Esther K. Ericson(b) Address 4720 Lincoln Ave, Chicago,

17. (a) Removal (b) Date thereof 11/1/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Illinois18. (a) Signature of funeral director Albert H. Hoppe(b) Address 4700 Washington Blvd.,

19. (a) NOV 2 1948 (b) J. B. Laster
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Cook **999**
 (c) City or town Chicago **2**
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4720 Lincoln Ave.
 (If rural, give location)
 (e) Citizen of foreign country? NR. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 1
 year 1948 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct.
3, 1948, to Nov. 1, 1948

that I last saw him alive on Nov. 1, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to PneumoniaDue to PneumoniaDue to PneumoniaOther conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations Some ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of autopsy _____

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) (Means of injury)23. Signature A. M. Laster (M. D. or other) M. D.Address 4952 Maryland Avenue Date signed 11/2/48

St. Louis, Mo.

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 *Frank J. Shaw*

Licensed Embalmer No. *2675*

P. O. Address *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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **9518**

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(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)

3. (a) PRINT FULL NAME **GOSTA ERICSON**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. **NOV. 17, 1948** (b) **J. E. Smith**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

20. DATE OF DEATH, Month **NOV.** day **1**
year **1948** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

PARKINSONISM
BRONCHIAL PNEUMONIA
TERMINAL
(Not from encephalitis)

Due to _____ 87c

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-34105