

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County Greene

Township \_\_\_\_\_

Village \_\_\_\_\_

City Springfield (NO. Finns Hospital)

Registration District No. 315

File No. 34390

Primary Registration District No. 200

Registered No. 629

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Edward Tegelberg

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE Single  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF DEATH October 24, 1911  
(Month) (Day) (Year)

DATE OF BIRTH April 2, 1894  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 10-22-11, 1911, to 10-23, 1911, that I last saw him alive on 10-23, 1911, and that death occurred, on the date stated above, at 1 P. m.

AGE 27 yrs. 6 mos. 21 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Burns  
181  
194 B  
107

OCCUPATION (a) Trade, profession, or particular kind of work Railroad Fireman  
(b) General nature of industry, business, or establishment in which employed (or employer) 4-67

BIRTHPLACE (City or town, State or foreign country) Dammanarna Sweden

PARENTS NAME OF FATHER Carl Tegelberg BIRTHPLACE OF FATHER (City or town, State or foreign country) Sweden  
MAIDEN NAME OF MOTHER Anna Tiger BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sweden

Contributory Shock + Emulsion  
(SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) [Signature] M. D.  
10-24 1911 (Address) Springfield Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. 2 ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
Where was disease contracted If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

(Informant) Anna Johnson

(ADDRESS) 7725 Langeman St Chicago

PLACE OF BURIAL OR REMOVAL Prophetic Care DATE OF BURIAL Oct 24, 1911

Filed 10-24 1911 [Signature] REGISTRAR

UNDERTAKER [Signature] ADDRESS 492 E Com St

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.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*; *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

*coma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgi al operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County Crestone

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Springfield

Registration District No. 318

File No. \_\_\_\_\_

Primary Registration District No. 2001

Registered No. 629

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If death occurred in a hospital or institution; give its NAME instead of street and number)

FULL NAME

Edward Tige Bourg

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED A  
(Write the word)

DATE OF BIRTH Apr. 2, 1884  
(Month) (Day) (Year)

AGE: 24 yrs. 6 mos. 21 ds.  
If LESS than 1 day, hrs. or min.

OCCUPATION  
(a) Trade, profession, or particular kind of work Railroad Fireman  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) Boymemane, Sweden

NAME OF FATHER Carl Tige Bourg

BIRTHPLACE OF FATHER (City or town, State or foreign country) Sweden

MAIDEN NAME OF MOTHER Sons, Tige

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sweden

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Johnson

(ADDRESS) 749 1/2 Sangreman St. Chicago

Filed 12-4-1911 243 SEB REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 24, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1911, to 10-23, 1911, that I last saw him alive on 10-23, 1911, and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH\* was as follows:  
Curus  Yes.

Contributory Shock & Excitation  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. H. Johnston M.D.  
10-24, 1911 (Address) Chicago, Mo.

\*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Maplepark Cem DATE OF BURIAL Oct 24, 1911

UNDERTAKER W. Kingner & Co. ADDRESS 432 E. Compt.

Original file, date Oct. 24, 1911 All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sar-*

coma, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

34390

County GreeneREGISTRARS SHALL NOT RE-  
CEIVE A FEE FOR CERTIFICATES  
UNTIL THEY ARE COMPLETED AS  
PRESCRIBED BY LAW.BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Township \_\_\_\_\_

Registration District No. 318File No. 34390

Village \_\_\_\_\_

Primary Registration District No. 2001

Registered No. \_\_\_\_\_

City Springfield (NO. Frisco Hospital St.; \_\_\_\_\_ Ward)[If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number]FULL NAME Edward Tegelberg

## PERSONAL AND STATISTICAL PARTICULARS

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_ SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(If write the word)DATE OF BIRTH \_\_\_\_\_, 191\_\_\_\_  
(Month) (Day) (Year)AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.?OCCUPATION  
(a) Trade, profession, or  
particular kind of work \_\_\_\_\_(b) General nature of industry,  
business, or establishment in  
which employed (or employer) \_\_\_\_\_BIRTHPLACE  
(City or town,  
State or foreign country) \_\_\_\_\_NAME OF  
FATHER \_\_\_\_\_BIRTHPLACE  
OF FATHER  
(City or town, State or foreign country) \_\_\_\_\_MAIDEN NAME  
OF MOTHER \_\_\_\_\_BIRTHPLACE  
OF MOTHER  
(City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE--

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 24, 191\_\_\_\_  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from  
\_\_\_\_\_ to \_\_\_\_\_, 191\_\_\_\_,

that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Extensive burn  
from steam  
of waterContributory  
(SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.(Signed) W. H. Haggboom M.D.  
\_\_\_\_\_ 191\_\_\_\_ (Address) Springfield Mo\*State the Disease Causing Death, or, in deaths from Violent Causes, state  
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR  
RECENT RESIDENTS)At place  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the  
State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.Where was disease contracted  
if not at place of death? \_\_\_\_\_Former or  
usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

All information called for must be written on this Supplementary Certificate.

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