

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

AUG 20 1930

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

Do not use this space.

~~21808~~
21808

1. PLACE OF DEATH

County Audrain Registration District No. 24
Township Prairie Primary Registration District No. 4018
City Ladonia (No. _____ St. _____ Ward _____)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME Anna Swanson Torreyson

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF C.A. Torreyson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. II-1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
66 8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer) House-work
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) Gottenborg
(STATE OR COUNTRY) Sweden

10. NAME OF FATHER Niles Swanson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Sweden

12. MAIDEN NAME OF MOTHER Anna Marie Carlson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Sweden

14. INFORMANT C A Torreyson
(Address) Ladonia Mo

15. FILED 7-12, 1930 W.K. McCall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July II-30 1930

17. I HEREBY CERTIFY, That I attended deceased from March-19, 1930, to July-II, 1930.
that I last saw h. or alive on July-II, 1930, and that death occurred, on the date stated above, at 2.45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
9:30

CONTRIBUTORY (SECONDARY) 900 (duration) yrs. 4 mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Place of Death

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Physical Signs
(Signed) W.K. McCall M. D.

7-II* 1930 (Address) Ladonia Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ladonia Mo. DATE OF BURIAL 7-13-1930

20. UNDERTAKER J.B. Clark ADDRESS Vandalia Mo

