

No. 2
1-10-33
-17-91
X.2142

AUG 14 1940
Registration District No. _____

399

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 23 years (Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME Carolina Augusta Haglund

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female race white

5. Color or race _____

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Charles V. Haglund

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased October 25 1849
(Month) (Day) (Year)

8. AGE: Years 90 Months 8 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Ringquist

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

14. Maiden name No record

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

16. (a) Informant David G. Haglund

(b) Address 4160 Cambridge

17. (a) Removal (b) Date thereof 7-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burdick, Kansas

18. (a) Signature of funeral director Dates Funeral Home

(b) Address Kansas City, Kansas

19. (a) July 7, 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 4160 Cambridge
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 6
year 1940 hour 8:27 minute _____ M.

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

Immediate cause of death Fracture of right femur
Traumatic shock

Due to _____

Due to _____

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

Duration _____

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy Autopsy

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) Contract

(b) Date of occurrence 7/5/40

(c) Where did injury occur? 4160 Cambridge Road
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? No (Specify type of place) _____
(e) Means of injury Fallen down stairs

23. Signature [Signature] (M. D. or other) _____

Address [Address] Date signed 7/6/40

C. H. Littel
Prof. Rledge
Before 5

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 D. Ross Blanford
Licensed Embalmer No. 4015
P. O. Address 1815 9th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.