

FILED AUG 9 1940

Registration District No. **378**

Primary Registration District No. **5440**

Registrar's No. **566**

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Medical Center for Federal Prisoners
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mos., 6 days
In this community 4 mos., 6 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wisconsin (b) County St. Croix
(c) City or town Baldwin
(If outside city or town limits, write "RURAL")
(d) Street No. P.O. Box 180
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8,
year 1940 hour 4 minute 05 P.M.

21. I hereby certify that I attended the deceased from March 2, 1940 to July 8, 1940,
that I last saw him alive on July 8, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Recurrence, Cerebral Hemorrhage
Duration Since Adm.

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy No

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) _____
(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? _____

3. (a) PRINT FULL NAME DAHL, Henry Olaf **410**

3. (b) If veteran, name war World War 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 Josephine Dromsrud Dahl 8. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased September 10, 1886
(Month) (Day) (Year)

8. AGE: Years 53 Months 9 Days 28
If less than one day hr. min.

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

10. Usual occupation Bank Teller & Bookkeeper

11. Industry or business Security State Bank

12. Name Christian Dahl

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

14. Maiden name Mathilde Olson

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

16. (a) Informant Deceased
(b) Address Springfield, Missouri

17. (a) Removal (b) Date thereof July 9, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baldwin, Wisconsin

18. (a) Signature of funeral director Alma Lohmeyer

(b) Address Springfield, Missouri

19. (a) July 9, 1940 (b) W. C. Handley M.D.
(Date received local registrar) (Registrar's signature)
Signature J. C. Sturgell, M.D. (M. D. or other) !
Address Clinical Director, MCFP Date signed _____

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, above space should be left blank.