

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13310

State File No. _____

Registration District No. 395

Primary Registration District No. 100

Registrar's No. 1291

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Cowley Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Non-Resident
years, months or days _____

3. (a) PRINT FULL NAME William Sandberg
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Daisy Sandberg
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased May 17 1994
(Month) (Day) (Year)

8. AGE: Years 4 Months 10 Days 13
If less than one day hr. _____ min. _____

9. Birthplace Street 200
(City, town, or county) (State or foreign country)

10. Usual occupation Funerary Septon

11. Industry or business FB
12. Name William Sandberg
13. Birthplace nearby 4
(City, town, or county) (State or foreign country)
14. Maiden name Opalene Bell
15. Birthplace nearby 4
(City, town, or county) (State or foreign country)

16. (a) Informant Daisy Sandberg
(b) Address Eldon Mo

17. (a) Removal (b) Date thereof April 1 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Eldon, Mo

18. (a) Signature of funeral director Phillip Funeral Home
(b) Address Eldon, Mo

19. (a) Apr 1 1941 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 66
(c) City or town Eldon
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 30
year 1941 hour 9:15 minute _____ P. M.
21. I hereby certify that I attended the deceased from March 23
1941, to _____ 19____;
that I last saw him alive on Mar. 30 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death acute thyrotoxicosis
Due to choleangitis, chronic
Due to remains appendicitis
Other conditions (Include pregnancy within 3 months of death) _____

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 2

23. Signature Margaret Jones (M. D. or other) R. O.
Address 3737 Main St. Date signed 3-31-41

Duration 30 hrs.
2 yrs.
2 yrs.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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, fact should be so stated above.