

FILED MAR 6 1944

Primary Registration District No. 5376

Registrar's No. 184

1. PLACE OF DEATH: **DeKalb**

(a) County **DeKalb**

(b) City or town **Rural Grand River Twp.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **DeKalb**

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

(d) Street No. **Grand River Twp.**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Olaf A. Erickson**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **3**
year **1944** hour **3** minute **05** A. M.

4. Sex **Male** 5. Color or race **white**

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

6. (b) Name of husband or wife **dead** 6. (c) Age of husband or wife if alive **dead** years

7. Birth date of deceased **Sept 4th. 1865**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1-25-1944** to **2-3-1944**
that I last saw him alive on **2-2-1944** and that death occurred on the date and hour stated above.

8. AGE: Years **78** Months **4** Days **29** If less than one day _____ hr. _____ min.

Immediate cause of death **Cancer of Stomache** Duration **?**

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

Due to _____

Due to _____

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

10. Usual occupation **Carpenter**

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name **Erick O. Erickson**

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

14. Maiden name **Anna Lisa**

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

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? _____

16. (a) Informant **Mr. R. Lapworth**

(b) Address **Cameron, Mo. R. F. D.**

17. (a) **Burial** (b) Date thereof **2-6-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Delano Cem. DeKalb Co. Mo.**

While at work? _____ (Specify type of place)

(e) Means of injury **?**

18. (a) Signature of funeral director **C. P. Bloom**

(b) Address **Cameron, Mo.**

19. (a) **2/7/44** (b) **C. P. Bloom**
(Date received by registrar) (Registrar's signature)

23. Signature **C. P. Bloom** (M. D. or other) **D.O.**

Address **Cameron, Mo.** Date signed **2-3-44**

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

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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. *1180*

P. O. Address *Cameron, Mo*

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.