

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 9 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18453

Registration District No. 174

Primary Registration District No. 30-35

State File No. _____

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Leflore

(b) City or town Livingston

(c) Name of hospital or institution 1819 Bloom. City
(If not in hospital or institution, write street number or location)

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

In this community 54 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Leflore

(c) City or town Livingston 54
(If outside city or town limits, write "RURAL")

(d) Street No. 1819 Bloom
(If rural, give location)

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

3. (a) PRINT FULL NAME Peter E. Stromberg

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4
year 1944 hour 5 minute 10 A.M.

21. I hereby certify that I attended the deceased from 10-19, 1938, to May 5, 1944,
that I last saw him alive on May 4, 1944,
and that death occurred on the date and hour stated above.

4. Sex ma (f) 5. Color or race w

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

6. (b) Name of husband or wife Charlotte Erickson

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

7. Birth date of deceased Aug 21 1889
(Month) (Day) (Year)

Immediate cause of death Coronary embolism

Duration

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>8</u>	<u>13</u>	hr. _____ min. _____

Due to arterio sclerosis & Oh myocarditis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93d

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

10. Usual occupation Laborer

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name Peter E. Stromberg

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

14. Maiden name not known

15. Birthplace Sveveden
(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 Mrs Frank Francis Kato

(b) Address Livingston, Mo

17. (a) Burial (b) Date thereof 5-7-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Livingston, Mo

18. (a) Signature of funeral director James F. Jumper

(b) Address Livingston, Mo

19. (a) June 1-44 (b) Mrs. Fred Schwab
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature Dr. R. J. ... (M. D. or other) _____

Address Livingston, Mo Date signed 6/3/44

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6-8-47

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

Garrest J. Truiper

Licensed Embalmer No.

3278-

P. O. Address

Lexington, 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.