

FILED FEB 14 1945
Registration District No. 186

Primary Registration District No. 5391

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Texas
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
X
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X (Specify whether
In this community most of her life
years, months or days)

3. (a) PRINT FULL NAME Sarah Christiana Tohlen

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

4. Sex female 5. Color or race W 6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Otto Tohlen 6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased April 22 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>8</u>	<u>16</u>	hr. min.

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

10. Usual occupation housewife

11. Industry or business X

12. Name Andy Carlson
13. Birthplace Sweden
(City, town, or county) (State or foreign country)
14. Maiden name Hannah Anderson
15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Paul A. Tohlen
(b) Address Salem Mo
17. (a) burial (b) Date thereof 1/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johnson
18. (c) Signature of funeral director Carl Johnson
(b) Address Salem Mo

19. (a) 1-11-45 (b) Geo. D. McCordly M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8
year 1945 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov. 1944, 19 to Jan 8, 1945
that I last saw h. ER alive on Jan 7, 1945, 1945
and that death occurred on the day and hour stated above.

Immediate cause of death intracranial hemorrhage
hypertension
Duration 2 days

Due to hypertension YEARS

Due to Arteriosclerosis YEARS

Other conditions UREMIA

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Major findings: Of operations —
Of autopsy —
PHYSICIAN 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?

While at work? (Specify type of place) (e) Means of injury

23. Signature Martin M. M.D. (M. D. or other) MD.
Address Salem Mo. Date signed 1-10-45

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

MOTHER FATHER

RECEIVED

Case No. h / Lic. No. E.

Case Number 245-96
Dated 2-12-45

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.....

Carl H. Jensen

Licensed Embalmer No.

2370

P. O. Address

Salem, Me.

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.

Registration District No. 100

Primary Registration District No. 5391

1. PLACE OF DEATH: dent
 (a) County.....
 (b) City or town..... Jean, Miss.
 (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.....
 In this community..... (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... (b) County.....
 (c) City or town.....
 (If outside city or town limits, write "RURAL")
 (d) Street No.....
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Sarah C. Johlen
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced.....
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....
 7. Birth date of deceased..... April 2 (Month) (Day) (Year)

8. AGE: Years 68 Months..... Days..... If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....
 13. Birthplace..... (City, town, or county) (State or foreign country)
 14. Maiden name.....
 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Data received local registrar)..... (b) (Registrar's signature).....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan year 1945 hour..... minute..... M.

21. I hereby certify that I 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.....

Due to..... hemia due to chronic arteriolar sclerosis (chronic arteriosclerosis) renal disease
 Due to.....
 Other conditions..... (include pregnancy within 3 months of death)

ADDITIONAL PHYSICIAN
 Major findings:.....
 Of operations.....
 Of 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).....
 (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) (c) Means of injury.....

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

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

5-1-107