

No. 2
8-4-47
17-30
7-1-47
K37823

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

FILED FEB 21 1947

5193

State File No. _____

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage

(c) Name of hospital or institution: Car Wreck 7 Miles No. on Highway 71

(d) Length of stay: In hospital or institution 3

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Minn. (b) County Hennepin 999

(c) City or town Minneapolis

(d) Street No. 5124 31st. Ave.

(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME August Hast SWANSEN

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 7th. year 1947 hour 11:50 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Emma A. Swansen

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased May 5 1878

8. AGE: Years 68 Months 9 Days 3

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Fractured Skull, Internal hemorrhage

Due to: Car wreck, 7 miles west on Highway #71, Broken left hip cap

Due to: Broken right femur

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

9. Birthplace Unknown Sweden

10. Usual occupation Unknown

11. Industry or business _____

12. Name Petter Swansen

13. Birthplace Unknown Sweden

14. Maiden name Marie

15. Birthplace Unknown Sweden

16. (a) Informant Mrs. Emma A. Swansen

(b) Address 5124 31st. Ave. Minneapolis

17. (a) Removal (b) Date thereof 2 9 47

(c) Place: burial or cremation Sunset Memorial

18. (a) Signature of funeral director Ed. C. Ulmer

(b) Address Carthage, Mo.

19. (a) 2-8-47 (b) L. B. Clinton

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Feb 7, 1947

(c) Where did injury occur? Carthage Jasper Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway #71

While at work? No

23. Signature of physician _____

Address _____ Date signed 7-8-47

MOTHER FATHER

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

139

47-2-111

MAR 21 1947

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.....
Gene C. Pugh
Gene. C. Pugh.

Licensed Embalmer No. 4231

P. O. Address Carthage, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 24

Registration District No. 157

Primary Registration District No. 5586

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Franklin
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME August H. Swarna

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased May 5
(Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Unknown

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day _____
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____
that I last saw him/her alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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?
_____ (Specify type of place)

While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-5193