

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 67

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Washington  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Franklin

(c) City or town Pacific 36  
(If outside city or town limits, write "RURAL")

(d) Street No. 2  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country ✓

3. (a) PRINT FULL NAME Cornelius Bert Ohlin

3. (b) If veteran, name war no

3. (c) Social Security No. none

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

6. (b) Name of husband or wife Ann Ohlin 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Oct. 19 1887  
(Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 27 hr.     min.    

9. Birthplace St. Joseph, Mich.  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Gen'l Laborer

12. Name unknown

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

14. Maiden name Myra Emma

15. Birthplace Mich.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Myrtle Ohlin

(b) Address Pacific Mo.

17. (a) Burial (b) Date thereof 4/18/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pacific Mo.

18. (a) Signature of funeral director W. J. Fisher

(b) Address Pacific, Mo.

19. (a) APR 17 1947 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16  
year 1947 hour 5 minute     P.M.    

21. I hereby certify that I attended the deceased from March 4  
47, 1947, to March 16, 1947  
that I last saw him alive on March 16, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to    

Due to    

Other conditions 936  
(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?    

While at work?     (Specify type of place)

(e) Means of injury    

23. Signature [Signature] (M. D. or other)    

Address Washington, Mo. Date signed 4/18/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed APR 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..... *Jno. L. Shieles*.....  
Licensed Embalmer No. *3008*.....  
P. O. Address..... *Pacific 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.