

FILED JAN 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 862

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	
c. LENGTH OF STAY (In this place) <u>1 year</u>		d. STREET ADDRESS (If rural, give location) <u>1000 East Chestnut</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1000 E Chestnut</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Himberg</u> b. (Middle) _____ c. (Last) <u>Anderson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 17 1949</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 4, 1872</u>	9. AGE (In years last birthday) <u>76</u>	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labour</u>	11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>E. H. Frahm, 1000 E Chestnut, Springfield</u>	ADDRESS <u>Springfield</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Abdominal malignancy, type undetermined.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis</u>		<u>10 years</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Feb. 26, 1948, to Jan. 17, 1949, that I last saw the deceased alive about Nov., 1948, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Wm. S. Harris M.D.</u> (Degree or title)	23b. ADDRESS <u>Medical Arts Bldg. Springfield, Missouri</u>	23c. DATE SIGNED <u>1-17-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Jan 18, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Acacia Park</u>	24d. LOCATION (City, town, or county) (State) <u>Minneapolis, Minnesota</u>
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DATE REC'D BY LOCAL REG. <u>1-18-49</u>	REGISTRAR'S SIGNATURE <u>W. S. Handy M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Lohmeyer Funeral Home,</u>	ADDRESS <u>Springfield, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

MAR 24 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Jewell E. Kinick

Signed _____
Student Embalmer

Licensed Embalmer No. *2831*

P. O. Address *Spring field*

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.