

MISSOURI STATE BOARD OF HEALTH

Do not use this space.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39849

1. PLACE OF DEATH

County Sevier Registration District No. 820
Township 2 Primary Registration District No. 6069
City Sevier (No.) St. Ward

File No.
Registered No.
St. Ward

2. FULL NAME

(a) Residence, No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sep. 28, 1900
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 34 2 2

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Bank
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Bank
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brampton Del

13. NAME May Cross

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Del

15. MAIDEN NAME Jas. Lundquist

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

17. INFORMANT (ADDRESS) Jos. Beklund

18. BURIAL, CREMATION, OR REMOVAL PLACE Cape County
Fairview Cemetery 12/30/34

19. UNDERTAKER (ADDRESS) G. D. Heiser

20. FILED 12/9 1934 G. J. Chican Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/30, 1934
22. I HEREBY CERTIFY, That I attended deceased from 11/18, 1934, to 11/30, 1934.
I last saw her alive on 11/30, 1934. Death is said to have occurred on the date stated above, at 10 P.M.

The principal cause of death and related causes of importance were as follows:

Nephritis (Acute)
190
110
Other contributory causes of importance: Hypertension

Name of operation None Date of
What test confirmed diagnosis? Urine Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? Yes
If so, specify
(Signed) Abraham, M. D.
(Address) Rope Manufacturing

DEC 26 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

WITH ME THIS 2nd day
of Dec 1931
File No. *File 1000*
Registered *Paq. Ward*
Dist 870

1. PLACE OF DEATH

County Scott Registration District No. 6069 820
Township Sylvania Primary Registration District No. 6069
Address Randles Mo. St. _____

2. FULL NAME Essie Beklund.

(a) Residence. No. Randles Mo. St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married.
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jesse Beklund.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 28th 1900

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
31 2 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Braughton, Ill
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Jas Hendrickson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Cross.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
(STATE OR COUNTRY)

14. INFORMANT Jos Beklund.

(Address) Randles.

15. FILED 12/2 31 G. J. Slickman.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/30 19 31

17. I HEREBY CERTIFY That I attended deceased from 11/18 19 31 to 11/30 19 31
that I last saw her alive on 11/30 19 31 and that death occurred, on the date stated above, at 10 1/4 m. P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Nephritis (Acute)

CONTRIBUTORY Hypertension
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? none DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Urine.

(Signed) _____, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.) No.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairveiw Cemetary DATE OF BURIAL 12/2 19 31

20. UNDERTAKER T. S. Heisserer and Co. ADDRESS Oran Mo.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scott Registration District No. 820 File No.
Township Sylvania Primary Registration District No. 6069 Registered No.
City (No.) St. Ward)

2. FULL NAME

Essie Becklund

(a) Residence, No. St., Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.

19. UNDERTAKER (ADDRESS)

20. FILED 19. [Signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 30 1931

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...

I first saw h. alive on 19... Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Acute nephritis Date of onset

Other contributory causes of importance: Cause Un known

Name of operation Date of

What test confirmed diagnosis? 130 Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) , M. D.

(Address)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation