

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 31 1935

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

Do not use this space.

13557

1. PLACE OF DEATH

County Marion Registration District No. 547
 Township Marion Primary Registration District No. 3079
 City Hannibal (No. 1309 Russell St) St. _____ Ward _____

File No. _____
 Registered No. 117
 St. _____ Ward _____

2. FULL NAME

Elefander Erickson
 (a) Residence, No. 1309 Russell 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 16th 1852
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 - 25
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 14th 1935
 22. I HEREBY CERTIFY, That I attended deceased from March 27, 1935, to April 11, 1935
 I last saw him alive on April 11, 1935 Death is said to have occurred on the date stated above, at 5¹⁵ a.m.
 The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance: _____
Senility
 Date of onset _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden
 13. NAME John Erickson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden
 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT Mrs Leo H. Paise
 (ADDRESS) 1309 Russell St Hannibal, Mo
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE Grandview Memorial Park DATE 4/14/35 19____
 19. UNDERTAKER James O Powell
 (ADDRESS) Hannibal, Mo
 20. FILED Apr 17 1935 R. H. Webster
Deputy Registrar

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) O. E. Salzer, M. D.
 (Address) Hannibal, Mo.

