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.

SEP 25 1935

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

Do not use this space.

26437

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township ~~Kaw~~ — Primary Registration District No. 1002 — Registered No. 3184

City Kansas City (No. General Hospital St. Ward)

2. FULL NAME Arthur Haglund

(a) Residence, No. 3317½ East 31st. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 21, 1933

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
1	11	17 (17)	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

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) Denver Colo

FATHER

13. NAME Helmer Haglund

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

MOTHER

15. MAIDEN NAME A lice McWhorter

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.

17. INFORMANT (ADDRESS) Mother Alice Haglund Kansas City, Missouri

18. BURIAL, CREMATION, OR REMOVAL

PLACE Greenlawn Cem. DATE 8-12-35, 19

19. UNDERTAKER (ADDRESS) Mellody-McGilley Kansas City, Mo.

20. FILED Aug 11, 1935 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/8/35, 19

22. I HEREBY CERTIFY that I attended deceased from Dysentery Chronic, 19, to, 19

I last saw h alive on 1:25 P, 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:

Fracture of the Skull — Date of onset

186a

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? 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 8/8/35

Where did injury occur? 3317½ E 31st St. Cleveland (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fell out of 2nd floor window

Nature of injury

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

If so, specify

(Signed) , M. D.

(Address)