

REC'D APR 15 1938

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

10992  
Do not use this space.

1. PLACE OF DEATH  
(a) County Jackson Registration District No. 398  
(b) Township Blue Primary Registration District No. 5554 Registered No. 89  
(c) City K. C. Mo. (d) Street No. 3610 Hunter Avenue, K. C. Mo. St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hilda Ostlund, 234  
(a) Residence, No. 3610 Hunter Avenue, K. C. Mo. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Robert Ostlund,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 9th, 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
60 10 15

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. At Home  
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) Sweden

FATHER  
13. NAME August Holmquest  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

MOTHER  
15. MAIDEN NAME No Record  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT Mr. Robert Ostlund,  
(ADDRESS) 3610 Hunter Avenue, K.C.Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Floral Hill, DATE Mich. 24th, 1938

19. FUNERAL DIRECTOR Mrs. C. L. Forster  
(ADDRESS) 918 Brooklyn Avenue, K.C. Mo.

20. FILED 3-28-38 J. L. Grobe Local Registrar. 360

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 22nd, 1938

22. I HEREBY CERTIFY, That I attended deceased from Mar 5, 1938, to Mar 27, 1938  
I last saw her alive on Mar 22, 1938 Death is said to have occurred on the date stated above, at 12:30 P.M.  
The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage Date of onset 3-5-38  
925'

Other contributory causes of importance:  
Initial Suffering

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? none Was there an autopsy? no

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? no  
If so, specify \_\_\_\_\_  
(Signed) Carl Jackson, M. D.  
(Address) 507 Dimes

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

Douglas A. Jackson  
Commerce Trust Bldg., City.

12,00 Nov  
922 2112

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....  
..... L. E. ....  
No..... or by....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**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.)**