

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D MAR 13 1939

791
1003

4898
Do not use this space.

1. PLACE OF DEATH

- (a) County..... 1 Registration District No..... 2
- (b) Township..... Primary Registration District No.....
- (c) City St. Louis Mo. (d) Street No. BARNES HOSPITAL St. (If death occurred in Hospital or Institution, write its name instead of street and number)
- (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 Oscar F. Ekholm

- (a) Residence, No. (Usual place of abode, if no street address, write county or city) St. WR Windom Kansas (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lillie Ekholm</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 29, 1879</u>				
7. AGE	YEARS <u>59</u>	MONTHS <u>2</u>	DAYS <u>18</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>FARMER</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sweden</u>			
	13. NAME <u>Aron Ekholm</u>			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sweden</u>			
	15. MAIDEN NAME <u>Matilda Nelson</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sweden</u>				
17. INFORMANT <u>Lillie Ekholm,</u> (ADDRESS) <u>Windom, Kansas.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Windom, Kansas.</u> DATE <u>Feb. 21, 1939</u>				
19. FUNERAL DIRECTOR (NAME) <u>Oxenhandler F. Ds.</u> (ADDRESS) <u>4469 Washington</u>				
20. FILED <u>FEB 18 1939</u> <u>J.P. Budick</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 18 - 1939

22. I HEREBY CERTIFY, That I attended deceased from 2 - 6 - 1939, to 2 - 18 - 1939
I last saw him alive on 2 - 18 - 1939. Death is said to have occurred on the date stated above, at 5:30 a.m.
The principal cause of death and related causes of importance were as follows:
Broncho pneumonia - pneumococci 16.16.
55 d
Date of onset

Other contributory causes of importance:
Cerebral neoplasm, unknown as to malignancy. Not a complete autopsy.

Name of operation Craniotomy Date of 19 Feb 39
What test confirmed diagnosis? Ventriulo-graphy Was there an autopsy? Yes

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) E. L. Coons, Jr., M. D.
(Address) Windom, Kansas

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 me

Registered Apprentice No., working under my personal supervision.

Signed

Philip M. Lewis

Licensed Embalmer No. 3281

P. O. Address 4468 Washington

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, above space should be left blank.