

FILED MAR 11 1940
309

Registration District No. 309

Primary Registration District No. 4185

Registrar's No. 5

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Gentry
 (b) City or town Albany
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Rose Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 Months
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Cecilia Anderson 536

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lars Anderson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 14 1850
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>3</u>	<u>12</u>	hr. _____ min.

9. Birthplace Matröd Sweden
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Johanna Berggren

13. Birthplace Unknown Sweden
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. G. E. Kling

(b) Address Albany, Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mead Cemetery

18. (a) Signature of funeral director W. H. Burch
 (b) Address Albany, Mo.

19. (a) July 26 1940 (b) W. T. Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Nebraska (b) County _____
 (c) City or town Mead
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? Fifty-seven years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 26
 year 1940 hour 10:30 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Nov. 10-1939
1-26-1940 to _____, 19____;
 that I last saw h. or alive on 1-26-1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Coryza
Hypostatic pneumonia

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

Duration
1-24-40

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) fracture of left hip
 (b) Date of occurrence Nov 9 1939
 (c) Where did injury occur? Mead neb
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
281 home

While at work? yes (Specify type of place) (e) Means of injury fall

23. Signature Frank H. Rose (M. D. or other) pn. D.
 Address Albany, Mo Date signed 1-26-40

RECEIVED
District Health Officer No. 11,
District File Number 244-229
Date Filed MAR 5 1940

APR 30 1938

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 Clifford Burke
Licensed Embalmer No. 3329
P. O. Address Albany, Mo.

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.