

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **10605**

Registration District No. **163**

Primary Registration District No. **5228**

Registrar's No. **22**

1. PLACE OF DEATH:

(a) County **Cedar**  
(b) City or town **RURAL - Box 1111**  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2**  
(Specify whether

In this community  
years, months or days) **1111**

8. (a) PRINT FULL NAME **CHRISTINA ENGLUND**

8. (b) If veteran, name war: \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife **Frick Englund** 6. (c) Age of husband or wife if alive **84** years

7. Birth date of deceased **Aug-29-1855**  
(Month) (Day) (Year)

8. AGE: Years **84** Months **6** Days **13** If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **housewife**

11. Industry or business \_\_\_\_\_

12. Name **Johnson**

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

14. Maiden name **unknown**

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

16. (a) Informant **Rev David Englund**

(b) Address **Eldorado Springs, Mo. P3**

17. (a) **Burial** (b) Date thereof **Mar-14-1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Stentonville Cemetery**

18. (a) Signature of funeral director **Levin-Siders**

(b) Address **Eldorado Springs, Mo**

19. (a) **Mar 13-40** (b) **W Dawson**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **CEGAR**

(c) City or town **RURAL**  
(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.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **12**  
year **1940** hour **1:30** minute **P** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy**  
**Dead when taken to bed**

Due to \_\_\_\_\_

Due to \_\_\_\_\_ **82k**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **154**

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **W Dawson** (M. D. or other) **!**

Address **Eldorado Springs** Date signed **3/13/40**

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 7,  
District Health Number 4-40-562  
District File Number 4-8-40  
Date Filed

**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 \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.**