

Registration District No. 13

Primary Registration District No. 4010

Registrar's No. 29

## 1. PLACE OF DEATH:

(a) County Andrew  
 (b) City or town Savannah  
 (c) Name of hospital or institution:  
The North Sanatorium  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Savannah 15 days  
 (Specify whether  
 In this community 14 days  
 years, months or days)

## 3. (a) PRINT FULL NAME

John Hedlund 345

## 3. (b) If veteran

name war none

## 3. (c) Social Security

No. none4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed6. (b) Name of husband or wife Augusta Hedlund 6. (c) Age of husband or wife if alive years7. Birth date of deceased July 31 1850  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
89 11 16 7 hr. 35 min.9. Birthplace unknown Sweden  
(City, town, or county) (State or foreign country)10. Usual occupation Retired grocer11. Industry or business 712. Name unknown13. Birthplace unknown Sweden  
(City, town, or county) (State or foreign country)14. Maiden name unknown15. Birthplace unknown Sweden  
(City, town, or county) (State or foreign country)16. (a) Informant Nelson Berger Funeral Home(b) Address Sioux City Iowa17. (a) removal (b) Date thereof July 17 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Sioux City Iowa18. (a) Signature of funeral director Frank A. Bowman(b) Address Savannah Mo.19. (a) July 17-40 (b) Mrs. Jennie Rash  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Andrew  
 (c) City or town Sioux City  
 (If outside city or town limit write "RURAL")  
 (d) Street No. 1020 Virginia St  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 50 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 17  
year 1940 hour 9 minute 35 A.M.21. I hereby certify that I attended the deceased from 7-2-1940  
1940 to 7-17-1940  
that I last saw h. in alive on 7-17-1940  
and that death occurred on the date and hour stated above.Immediate cause of death Basinoma  
nightcheck, for carcinoma  
legum. about  
1 yr.Due to ✓

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

Other conditions arteriosclerosis, kidneys  
(Include pregnancy within 3 months of death)

## Major findings:

Of operations \_\_\_\_\_

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

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

## 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?  
934While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature Willard G. Stearns (M. D. or other) MDAddress Savannah Mo. Date signed 7-17-40

45  
RECEIVED

District Health Officer No. 11,

District File Number 870-1080

Date Filed AUG 12 1940

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 7/17/40

Registered Apprentice No.

working under my personal supervision.

Signed

B. D. Mc. Summerfield

Licensed Embalmer No. 2007

P. O. Address 319 E. St. Joseph, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 24482

Registration District No. 13

Primary Registration District No. 4010

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Savannah  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME John Hedlund  
3. (b) If veteran \_\_\_\_\_ name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year \_\_\_\_\_  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days 16 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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.

20. DATE OF DEATH: Month 11 day 17  
year 1940 hour 11 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw \_\_\_\_\_ live on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death right chest ear and mastoid. Squamous  
Due to 1st

Other conditions arterio sclerosis  
(Include pregnancy within 3 months of death)  
kidney

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_ 45

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?

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

23. Signature Willard A. Stearns  
Address Savannah Date Nov

SUPPLEMENTAL

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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