DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34959

Registration District No. 1908

Primary Registration District No. 3008

Registrar's No. 280

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: The Callaway Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Nine hours (Specify whether
In this community ✓ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Lee

(c) City or town Montrose - Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 8 Miles N.W. of Keokuk
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Linda Larsen

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Martin Larsen

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased February (Month) 15 (Day) 1875 (Year)

8. AGE:

Years	Months	Days	If less than one day
65	8	12	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Jacobsen
13. Birthplace (City, town, or county) Norway (State or foreign country)

MOTHER
14. Maiden name DK
15. Birthplace (City, town, or county) DK (State or foreign country)

16. (a) Informant Martin Larsen
(b) Address Montrose, Iowa

17. (a) removal (Burial, cremation, or removal) (b) Date thereof Oct (Month) 28 (Day) 1940 (Year)
(c) Place: burial or cremation Keokuk, Iowa

18. (a) Signature of funeral director Leo G. Wallace
(b) Address Fulton, Missouri

19. (a) Oct. 28, 1940 (Date received local registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27 year 1940 hour 9:30 minute P M.

21. I hereby certify that I attended the deceased from Oct 27 - 12 noon, 1940, to Oct 27 9:30, 1940, that I last saw her alive on Oct 27, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid Hemorrhage

Due to Fracture of base of skull

Due to Automobile accident

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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) Accident
(b) Date of occurrence Oct 27 1940.
(c) Where did injury occur? Kingdom City (City or town) Callaway (County) No. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway #40. (Specify type of place)
While at work? No (e) Means of injury Auto accident

23. Signature [signature] (M. D. or other)
Address Fulton Mo Date signed 10-28-40

(Licensed Embalmer's Statement on Reverse Side)

210 m
98

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 Harold J. Christy

Licensed Embalmer No. 4002

P. O. Address Dulton, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34959

Registration District No. 104 Primary Registration District No. 3008 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Callowan

(b) City or town Fulton
(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)

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.

3. (a) PRINT FULL NAME Linda Larsen

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 12 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27
year 1940 hour minute 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 Subarachnoid Hemorrhage

Due to Fracture of base of skull

Due to Automobile accident
Callowan with another auto

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 210 m

Of autopsy

Duration

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) acc

(b) Date of occurrence Oct-27-1940

(c) Where did injury occur? Kingdom City (City or town) (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Hgw #40 (Specify type of place)
While at work? no (e) Means of injury Wht Elbow.

23. Signature (M. D. or other)
Address Date signed