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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35330

MAILED NOV 12 1940
318

State File No. _____

Registration District No. _____

Primary Registration District No. 2001

Registrar's No. 847

1. PLACE OF DEATH:

(a) County Brunswick
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1907 W. Olive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 24 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Brunswick
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1907 W. Olive
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 38 years.

3. (a) PRINT FULL NAME Mr Per Olaf Person

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Signe Person 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased November 1, 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 11 Days 13 If less than one day hr. min.

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

10. Usual occupation Shoe Maker

11. Industry or business Same

12. Name Olaf Person

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

14. Maiden name Unknown Person

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

16. (a) Informant Mrs. Signe Person

(b) Address 1907 W. Olive Springfield Mo.

17. (a) Burial (b) Date thereof 10/17/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hazlewood

18. (a) Signature of funeral director F. C. Higgins

(b) Address Springfield Mo

19. (a) 10-17-40 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14th
year 1940 hour 10:55 minute _____ P. M.

21. I hereby certify that I attended the deceased from one visit
10-14, 1940 10-14, 1940
that I last saw him alive on 10-14-40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction

Due to MI

Other conditions Bronchial asthma
(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? At home

(e) Means of injury _____ (Specify type of place) While at work _____

Signature W. E. Handley M.D. (M. D. or other) _____
Date signed 10/15/40

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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

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.....

Fred C. Thiene

Licensed Embalmer No. *2899*

P. O. Address *Springfield, 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, fact should be so stated above.

X