

No. 5-42
17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29662

Registration District No. 378

Primary Registration District No. 6285 45

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Wright

(b) City or town Mountain Grove
(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..... (Specify whether)

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright

(c) City or town Mountain Grove
(If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country..... 0

3. (a) PRINT FULL NAME John O. Forsling

3. (b) If veteran, name war No

3. (c) Social Security No. 720

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug, day 9, year 1943 hour 8 minute 50 A.M.

21. I hereby certify that I attended the deceased from 7-26-1943 to 8-9-1943 that I last saw him alive on 8-8-1943 and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Elizabeth Forsling alive

6. (c) Age of husband or wife if alive 18 years

7. Birth date of deceased February 26, 1872
(Month) (Day) (Year)

Immediate cause of death Coronary Heart disease

Duration 2 yrs

8. AGE: Years 71 Months 5 Days 13 If less than one day hr. min.

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 92d

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

10. Usual occupation Farmer

PHYSICIAN

Major findings: Of operations.....

Of autopsy.....

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business.....

12. Name John O. Forsling

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

14. Maiden name Bertha Johnson

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

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 J. G. Frame (M. D. or other)

Address Mountain Grove Mo. Date signed 8-14-43

16. (a) Informant Anna Clason

(b) Address Mtn. Grove Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12, 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Hillcrest Cemetery

18. (a) Signature of funeral director Russell Barber

(b) Address Mtn. Grove Mo.

19. (a) 8/12/43 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

1355

RECEIVED

District Health Officer No. 6;

District File Number 943-1033

Date Filed SEP 11 1943

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 Raymond B. [Signature]
Licensed Embalmer No. 3828
P. O. Address 212 [Signature] St.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *1000-29162*

Registration District No. _____

Primary Registration District No. _____

Registrar's No. *39*

1. PLACE OF DEATH:

(a) County *Wright*
(b) City or town *Monticello*
(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) (Specify whether

3. (a) PRINT FULL NAME *John O. Forsling*

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 *Married*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased *Feb. 26* (Month) (Day) (Year)

8. AGE: Years *71* Months *5* Days _____ If less than one day _____ min.

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

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) *8/12/43* (b) *[Signature]*
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) _____
(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-29662