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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

31449

State File No.

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 327

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution:
Ball Clinic O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community 7 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County 999

(c) City or town Eagle Grove 15
(If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Alma Johnson

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female

5. Color or race White 1

6. (a) Single, widowed, married, divorced Unknown 9

6. (b) Name of husband or wife

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

7. Birth date of deceased April 6 1891
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
52	4	26	hr. min.

9. Birthplace Humboldt Co. Iowa 1
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Torris Michlebust
13. Birthplace Norway 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Kathrine Houskin
15. Birthplace Norway 4
(City, town, or county) (State or foreign country)

16. (a) Informant J Heyler
(b) Address Clarion, Iowa.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 3-43
(Month) (Day) (Year)

(c) Place: burial or cremation Eagle Grove Iowa.

18. (a) Signature of funeral director Claude Richard
(b) Address Excelsior Springs, Mo.

19. (a) 9-3-43 Mrs Sadie Redman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 43 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from Aug 25-43, 19 to Sept 2-43, 19
that I last saw her alive on Sept 2 43, 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Cerebrae Thombus or Hemorrhage	3 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

83 b

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Thos Truelsen O. (M. D. ~~or other~~)
Address Excelsior Springs Mo Date signed 9/2 43

1166

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number .....

Date Filed 9-7-43

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 Earl Rapp

Licensed Embalmer No. 03458

P. O. Address Excelsior Springs, M

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.