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UNITED STATES BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **15948**

**FILED MAY 15 1944**

Registration District No. **357**

Primary Registration District No. **4499**

Registrar's No. **58**

**1. PLACE OF DEATH**

(a) County Shelby

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 4 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State \_\_\_\_\_ (b) County 102

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") 2

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

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

If yes, name country 0

**3. (a) PRINT FULL NAME** Carl August Erikson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MO 5. Color or race wh

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb 26 1923  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 4 day 27  
year 1944 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4-27-44 to 4-27-44,  
that I last saw him alive on 4-27-44,  
and that death occurred on the date and hour stated above.

**8. AGE:**

| Years     | Months   | Days     | If less than one day |
|-----------|----------|----------|----------------------|
| <u>21</u> | <u>2</u> | <u>1</u> | hr. _____ min. _____ |

Immediate cause of death Angina Pectoris

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

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

Other conditions Arterio-sclerosis  
(Include pregnancy within 3 months of death)

Duration 40 min

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Tailor

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

**MOTHER FATHER**

12. Name Astrid Erikson

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

14. Maiden name Anna Kaja Jonsson

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

Major findings: Of operations \_\_\_\_\_

Of autopsy 94 P

16. (a) Informant Erick Thielmann (Mrs. H. E.)

(b) Address Abernathy Texas

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof May 1 - 44  
(Month) (Day) (Year)

(c) Place: burial or cremation Dwight Hill

18. (a) Signature of funeral director E. J. Gayer

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

19. (a) May 3, 1944 (b) Madge L. Gayer  
(Date received local registrar) (Registrar's signature)

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 U. M. Wood (M. D. or other) \_\_\_\_\_  
Address Shelbina Mo Date signed 4-29-44

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

RECEIVED

District Health Officer No. 10

District File Number 5-44-992

Date Filed MAY 12 1944

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

*E. Hayes*

Licensed Embalmer No. 1487

P. O. Address .....

**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:**

Registration District No. 337

Primary Registration District No. 4499

1. PLACE OF DEATH:

(a) County Shelby Shelby  
(b) City or town Shelby  
(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 Carl G. Erikson

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 W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Feb 26 1907  
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (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) Malge Looch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County \_\_\_\_\_  
(c) City or town  Dwight (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? yes (Yes or No)  
If yes, name country Sweden

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ 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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

15948