

FILED MAY 24 1944

State File No. _____

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 459

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
910 West Hyde
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Since December 1943 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County Tom Green
(c) City or town San Angelo
(If outside city or town limits, write "RURAL")
(d) Street No. 829 Velma
(If rural, give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country Sweden

3. (a) PRINT

FULL NAME Mrs. Johanna C. Tauvar

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

4. Sex Female / Color or race White 5. Color or race White 6. (a) Single, widowed, married, divorced, widow 2 divorced, widow

6. (b) Name of husband or wife Louis F. Tauvar 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 16, 1870 (Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 19 If less than one day hr. min.

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

10. Usual occupation Trained Nurse

11. Industry or business _____

12. Name Johan Johnson

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

14. Maiden name Unknown Olson

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

16. (a) Informant Louis Tauvar

(b) Address 910 West Hyde

17. (a) Burial (b) Date thereof April 4, 1944 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden

(b) Address 602 South 10th Street

19. (a) 4-4-44 (b) Rose Herzog (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd year 1944 hour 6 minute A. M.

21. I hereby certify that I attended the deceased on April 3rd 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis
Due to: Acute indigestion of 4 weeks

Due to: Woman died suddenly in bed in her home (Include pregnancy within 3 months of death)

Other conditions: without previous serious illness other than attacks of indigestion for the past week
Major findings: Of operation: Of autopsy: no
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? _____

23. Signature H. J. Mundy (M. D. or other) (Specify type of place) (e) Means of injury _____
Address 404 1/2 3rd St. Joseph Mo Date signed 4/3/44

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

1233

7/44

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

Mollie E. Sidenaden Fo

Licensed Embalmer No.

4235

P. O. Address

St. Joseph, 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.