

21892

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 22, 1944

Registration District No.

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Wallace Memorial
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 45 minutes
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede 53
(c) City or town Phillipsburg (Rural) 0
(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 _____

3. (a) PRINT FULL NAME LLOYD LEONARD NYBERG

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 44-01-5314

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Gertrude Barnes 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Jan 24 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 3 25 hr. min.

9. Birthplace Laclede Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Electric Welder

11. Industry or business _____

12. Name John Nyberg 4

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

14. Maiden name Adelia Morris 9

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

16. (a) Informant Mrs Gertrude Nyberg

(b) Address Phillipsburg Mo.

17. (a) Burial (b) Date thereof 5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt Zion Cemetery

18. (a) Signature of funeral director W.E. Holman
(b) Address Lebanon Mo.

19. (a) 6-5-44 (b) Grace Roper
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19
year 1944 hour 8 minute 15 P.M.

21. I hereby certify that I attended the deceased from 5/19
1944, to 5/19 1944
that I last saw him alive on 5/19 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Internal chest injuries Duration 2 hrs

Due to fractured ribs of anterior chest wall 2 hrs

Due to _____
Other conditions shock; hemorrhage from scalp wound; fracture femur left.

Major findings: _____
Of operations _____
Of autopsy 170c - 8
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) accident 053

(b) Date of occurrence 5/19/44

(c) Where did injury occur? # 66; 10 mi west Lebanon, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
66

While at work? yes (Specify type of place) (e) Means of injury Car

23. Signature James L Hope, MD (M. D. or other)
Address Lebanon, Mo. Date signed 5/22/44

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

53
1
2

1090

(Licensed Embalmer's Statement on Reverse Side)

Received
Laclede County Health Unit
File No. 5-44-71
Date Filed 6/21/44

AUG 23 1944

JUL 5 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 *Dorsey M. Howe*
Licensed Embalmer No. *4222*
P. O. Address *Lebanon 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.