S. No. 2
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I X26390

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

27715

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

FILED SEP 9 1944

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 693

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: 428 W. Scott (If not in hospital or institution, write street number or location)

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

In this community 24 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield (If outside city or town limits, write "RURAL") 6

(d) Street No. 428 W. Scott (If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Anna C. Backlund

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Louis Backlund

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

7. Birth date of deceased Nov. (Month) 24 (Day) 1873 (Year)

8. AGE: Years 70 Months 9 Days 0 If less than one day ..... hr. ..... min.

9. Birthplace Unknown (City, town, or county) Sweden 4 (State or foreign country)

10. Usual occupation House wife

11. Industry or business .....

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) Unk. 9 (State or foreign country)

MOTHER
14. Maiden name Unknown Carolson
15. Birthplace Unknown (City, town, or county) Unk. 9 (State or foreign country)

16. (a) Informant Louis Backlund

(b) Address 428 W Scott, Spfd., Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26-44 (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn cem.

18. (a) Signature of funeral director Fred C. Thieme

(b) Address Springfield, Mo

19. (a) 8-24-44 (Date received local registrar) (b) Dr. W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24 year 1944 hour 17 minute 30 A.M.

21. I hereby certify that I attended the deceased from June, 1944, to ~~July~~ Aug 24, 1944 that I last saw her alive on Aug 22, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cardio Renal Vascular Disease — Duration 2 years

Due to .....

Due to .....

Other conditions ..... (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

131a

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 Max Pitch (M. D. or other) MD

Address Springfield Mo Date signed 8-24-44

(Licensed Embalmer's Statement on Reverse Side)

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 Fred C. Phiems

Licensed Embalmer No. 2-8-99

P. O. Address Springfield 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.