

FILED AUG 16 1944
Registration District No. _____

Primary Registration District No. 5636

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Phillipsburg (Rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Washington
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede
(c) City or town Rural
(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 CHARLES NYBERG

3. (b) If veteran, name war World war #1 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Rose Robertson 6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased April 24 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 1 26 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name John Nyberg
13. Birthplace Sweden
(City, town, or county) (State or foreign country)
14. Maiden name Adelia Morris
15. Birthplace Laclede Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Adelia Nyberg
(b) Address Lebanon Mo.

17. (a) Burial (b) Date thereof 6-23-44
(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) July 28-44 (b) Grace Roper
(Type received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20
year 1944 hour 10 minute 05 P. M.

21. I hereby certify that I attended the deceased from June 1
1944, to June 19, 1944
that I last saw him alive on June 19, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Myocardial Stenosis

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 P.O. Gannon (M. D. or other) M.D.
Address Buffalo Mo Date signed 6-23-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

-83
25-48

Received

Laclede County Health Unit

File No. 7-44-95

Date Filed 8/15/44

AUG 23 1944

MAY 24 1945

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.