

FILED MAY 12 1945

State File No. _____

Registration District No. 174

Primary Registration District No. 30.95

Registrar's No. 18

1. PLACE OF DEATH:
 (a) County Lafayette
 (b) City or town Livingston
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
17th Paplar
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 61 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Lafayette
 (c) City or town Livingston
(If outside city or town limits, write "RURAL")
 (d) Street No. 17th Paplar
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MATILDA NORD
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe! 5. Color or race W 6. (a) Single, widowed, married, divorced, Widow
 6. (b) Name of husband or wife Peter E. Nord 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 15 1959
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 8 29 _____ hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
 12. Name Carl Carlsson
 13. Birthplace Sweeden
(City, town, or county) (State or foreign country)
 14. Maiden name not known
 15. Birthplace Sweeden
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Joe Simms
 (b) Address Livingston, MO

17. (a) Burial (b) Date thereof 4-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Livingston, MO

18. (a) Signature of funeral director F. A. Kumpel
 (b) Address Livingston, MO

19. (a) May 5-45 (b) Mrs. Fred Schwab
(Date received at local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 14
 year 1945 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 11, 1945, to April 14, 1945;
 that I last saw him alive on April 14, 1945,
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
 Due to Arteriosclerosis

Duration 3 days
 Swallow

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

Major findings: Of operations None
 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)
 (e) Means of injury _____
 23. Signature Dr. Kumpel (M. D. or other) 4/14/45
 Address Livingston, MO Date signed _____

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

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 3
 2

1158

Byland

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5/11/42

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 *J. W. McKean*

Licensed Embalmer No. 29932

P. O. Address Washington, D.C.

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.