

S. No. 2  
M-2-43  
5-17-39  
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STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18444  
Registrar's No. 79

FILED JUN 7 1945  
Registration District No. 360

Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Vernon  
 (b) City or town Rural Washington Twp.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution State Hosp # 3  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 39 yrs 5 months 6 days  
 (Specify whether) 2  
 In this community same  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence  
 (c) City or town 158  
 (If outside city or town limits, write "RURAL") 6  
 (d) Street No. 0  
 (If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country

3. (a) PRINT FULL NAME Emma Loggren  
 3. (b) If veteran, name war No.  
 3. (c) Social Security No. 0

4. Sex M 5. Color or race W 6. (a) Single, widowed, married. 0  
 divorced. 0  
 6. (b) Name of husband or wife 0 6. (c) Age of husband or wife if  
 alive 0 years  
 7. Birth date of deceased May 15 1879  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 11 26 hr. min.

9. Birthplace Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation none

11. Industry or business

MOTHER FATHER { 12. Name Gustaf Loggren  
 13. Birthplace Suedia (City, town, or county) (State or foreign country) 4  
 14. Maiden name wife  
 15. Birthplace Sueden (City, town, or county) (State or foreign country) 4

16. (a) Informant Hospital Records  
 (b) Address Newada, Mo

17. (a) Burial (b) Date thereof 5/14/45  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Aurora, Mo

18. (a) Signature of funeral director J. F. King  
 (b) Address Aurora, Mo

19. (a) 5-16-45 (b) Hazel B. Bewick  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18<sup>th</sup>  
 year 1945 hour 12 minute 5 P.M.  
 21. I hereby certify that I attended the deceased from Feb 1st  
May 11th 1946 to May 11 1945  
 that I last saw her alive on May 11th 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
 Duration ✓

Due to  
 Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 930  
 Of operations  
 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 0

23. Signature H. P. Sammes (M. D. certified)  
 Address Newada, Mo. Date signed 5/14/45

RECEIVED

District Health Officer No. 7,

District File No. 5-43-488

Date Filed 6-6-43

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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.....

*Herman Purridge*

Licensed Embalmer No. 3072

P. O. Address. Aurora, 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

June

Registration District No. 360

Primary Registration District No. 6221

Registrar's No. 79

## 1. PLACE OF DEATH:

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

## 3. (a) PRINT FULL NAME

Emma Lafgren

3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 15  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

- MOTHER FATHER { 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

- (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

- (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Hazel B. Bewick  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County Lawrence  
 (c) City or town Aurora  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Route #1  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 15  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_;

- that I last saw h. \_\_\_\_\_, 19\_\_\_\_;

- and that death occurred on the date and hour stated above.

- Immediate cause of death \_\_\_\_\_

Duration

- Due to \_\_\_\_\_

- Due to \_\_\_\_\_

- Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

- Major findings:  
 Of operations \_\_\_\_\_

- 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)  
 (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

- Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

18944