

FILED DE 21 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 3035

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Jaffayette
(b) City or town Jefferson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(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 Algot Hanson

3. (b) If veteran, name war _____ 3. (c) Social Security No. 487-12-5495

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced ✓

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: aug 1882
(Month) (Day) (Year)

8. AGE: Years 63 Months — Days — If less than one day hr. _____ min. _____

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

10. Usual occupation carpenter

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Johu Birmingham

(b) Address Jefferson Mo

17. (a) Burial (b) Date thereof Nov 23, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jefferson Mo

18. (a) Signature of funeral director E. J. Herman
(b) Address Richmond Mo

19. (a) Dec 1944 (b) Ben E. Eubank
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jaffayette
(c) City or town Jefferson
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

If yes, name country Sweden

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20
year 1945 hour _____ minute 8-10 P.M.

21. I hereby certify that I attended the deceased from Nov 11
1945 to 20 Nov 1945
that I last saw him alive on 20 Nov 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration _____

Due to fractures

Due to _____

Other conditions Chronic myocarditis
(Include pregnancy within 3 months of death)

Major findings: none

Of operations _____

Of autopsy no

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 Ben H. Brasler (M. D. or _____)

Address Jefferson Mo Date signed 11/23/45

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-17-45.....

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.....

E. Sherman

Licensed Embalmer No. 2073

P. O. Address Richmond

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *1000*
Registrar's No. *212*

Registration District No. *171*

Primary Registration District No. *3035*

1. PLACE OF DEATH:
(a) County *Lafayette*
(b) City or town *Springton*
(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 *Algot Hansson*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *w*
6. (a) Single, widowed, married, divorced *widowed*
6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years *63* Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) *Sweden* (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director *E. Therman*
(b) Address *Rubens Memorial*

19. (a) _____ (b) *M. E. Eastman*
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year *1945* hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____ 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) (e) Means of injury _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

41627