DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2159

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 69

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1117 So. 15th St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether In this community 30 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 1117 So. 15th St. (If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME Lars Avard Nicklason

3. (b) If veteran, name war None

3. (c) Social Security No. 491-10-1495

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Alberta

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased March (Month) 17 (Day) 1885 (Year)

8. AGE: Years 60 | Months 10 | Days 0 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Fitter & Sub. Foreman

11. Industry or business Gas Service Co.

FATHER
12. Name Nicklason Olson
13. Birthplace Gottenburg (City, town, or county) Sweden (State or foreign country)

MOTHER
14. Maiden name Matilda Olson
15. Birthplace Gottenburg (City, town, or county) Sweden (State or foreign country)

16. (a) Informant Mrs. Alberta Nicklason

(b) Address 1117 So. 15th. St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21, 1946 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Herman Wm Hedenfeden

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Jan. 21, 1946 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17 year 1946 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from 7 Dec., 1945 to 17 January, 1946 that I last saw him alive on 17 Jan., 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage Apoplexy	1 day
Due to Hepatitis Senility	6 mem
Due to Toxic from gas fumes	?
Other conditions None (Include pregnancy within 3 months of death)	

Major findings: Of operations None

Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Toxic from gas

(b) Date of occurrence Period 13

(c) Where did injury occur? St. Joseph, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)

While at work? Gas Works (e) Means of injury Gas

23. Signature [signature] (M. D.)

Address St. Joseph, Mo Date signed 10 Jan

(Licensed Embalmer's Statement on Reverse Side)

1315

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 Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St. Joseph

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

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

DEPARTMENT OF COMMERCE
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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 69

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(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)

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

3. (a) PRINT FULL NAME Lars A. Nicklason

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Mar (Month) 17 (Day) 1878 (Year)

8. AGE: Years 60 Months 10 Days 0 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

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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 18
year 1946 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to worked in gas	178 A-8
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) no

(b) Date of occurrence none

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)

While at work? none (e) Means of injury none

23. Signature Cy Thorne (M. D. or other)

Address St Joseph Mo Date signed 14 Feb 46

SUPPLEMENTARY

2159