

Registration District No. 200

Primary Registration District No. 5725

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Shel. Hildrith Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Karl Axelberg

3. (b) If veteran, name war

(c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Louise M. Axelberg 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased Oct 27 - 1880
(Month) (Day) (Year)

8. AGE: Years 66 Months 7 Days 25 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Karl Erik Axelberg 4
13. Birthplace Sweden (City, town, or county) (State or foreign country)
14. Maiden name Aina Sophia Erikson
15. Birthplace Sweden (City, town, or county) (State or foreign country)

16. (a) Informant Arthur Axelberg
(b) Address Fredricksburg Iowa
17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof Apr 26 - 47 (Month) (Day) (Year)
(c) Place; burial or cremation Fredricksburg Iowa

18. (a) Signature of funeral director Arthur S. Skinner
(b) Address Macon Mo

19. (a) 5-10-47 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(g) State Iowa (b) County Bremser 999
(c) City or town Rural 12
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 3
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 22
year 1947 hour 7 minute 45 A.M.
21. I hereby certify that I attended the deceased from APRIL 12 1947 to APRIL 22 1947
that I last saw him alive on APRIL 22 1947
and that death occurred on the date and hour stated above.

Immediate cause of death ACUTE CARDIAC DILATATION

Due to

Other conditions PRE-SENILE DEMENTIA
(Include pregnancy within 3 months of death)

Major findings:
Of operations 950
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) (e) Means of injury 2
23. Signature R. H. Still (M. D. or other) D.O.
Address Macon Mo Date signed Apr 22 47

RECEIVED
District Health Officer No. 10
District File Number 5-47-130
Date Filed MAY 14 1947

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

Albert Skinner

Licensed Embalmer No.

75-1

P.O. Address

Mason m

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 CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *May*

Registration District No. *200*

Primary Registration District No. *5725*

Registrar's No. *1947*

1. PLACE OF DEATH:

(a) County *Macou*
(b) City or town *Rural*
(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

Karl Arling

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

6. (b) Name of husband or wife

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

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

Oct 27

8. AGE: Years Months Days

66

7

12

12

12

12

12

12

12

12

12

12

12

12

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

Sueden

10. Usual occupation

11. Industry or business

12. Name

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

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

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) *5/5/47* (b) *Ruth McNeely*

(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 *5* year *1947* hour *12* minute *22* M.

21. I hereby certify that I attended the deceased from *10* to *10*, 19*47*; that I last saw him alive on *10*, 19*47*; 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) Date signed

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

SUPPLEMENTARY

14135