

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 4 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17864

State File No.

Registration District No. 155

Primary Registration District No. 5579

Registrar's No. 88

1. PLACE OF DEATH:

(a) County Jeffer
(b) City or town Parcell
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
RURAL - MINERAL TOWNSHIP
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community 6 1/2 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jeffer
(c) City or town Parcell
(If outside city or town limits, write "RURAL")
(d) Street No. RURAL - MINERAL TOWNSHIP
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME

John Holmgren

3. (b) If veteran name was
3. (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 Hena Holmgren 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased March 13 1872
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 12 hr. 11 min.

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

10. Usual occupation Driver

11. Industry or business

12. Name J. Holmgren

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

14. Maiden name Anna Holmgren

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

16. (a) Informant John Holmgren

(b) Address Parcell, Mo.

17. (a) Burial (b) Date thereof May 28 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parcell, Mo.

18. (a) Signature of funeral director W. H. Cityland Co.

(b) Address W. H. Cityland Co.

19. (a) MAY 27 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1947 hour 11:27 minute P. M.

21. I hereby certify that I attended the deceased from April 1
1947, to May 25 1947.
that I last saw him alive on May 16 1947.
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary congestion Duration 10 days

Due to chronic nephritis

Due to Paralyzed bladder & urinary retention - cystitis 6 yrs.

Other conditions: [None]
(Include pregnancy within 3 months of death)

Major findings: Of operations [None]
Of autopsy [None]

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 Robert M. Ferguson MD (M. D. or other)

Address W. H. Cityland Co. Date signed 5-27-47

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

MOTHER FATHER

47-5-173

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 myself.

....., Registered Apprentice No.
working under my personal supervision.

Signed Blayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City, 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.