

FILED AUG 25 1948

Registration District No. 70

Primary Registration District No. 423

Registrar's No. 45

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

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Wayland
(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.....
In this community.....
years, months or days

3. (a) PRINT FULL NAME Wilhelmina Larson

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

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

6. (b) Name of husband or wife Gustafson Larson 6. (c) Age of husband or wife if alive 75

7. Birth date of deceased April - 6 - 1875
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 130
If less than one day hr. min.

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

10. Usual occupation at Home

11. Industry or business

MOTHER FATHER

12. Name Carlson

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

14. Maiden name Not known

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

16. (a) Informant Glen Larson
(b) Address Winnapolis Minn

17. (a) Buried (b) Date thereof 8-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kabok Cemetery

18. (c) Signature of funeral director Fred Karle
(b) Address Kabok 200
19. (a) 76-48 (b) J. R. Rudge
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clark
(c) City or town Wayland
(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 Aug day 16
year 1948 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from Aug 14, 1948 to Aug 16, 1948
that I last saw her alive on Aug 16, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to sclerosis of arteries

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations g 30
Of autopsy.....

Duration
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) (Means of injury)
23. Signature J. M. Chyze (M. D.)
Address Rolla Mo Date signed Aug 17 48

RECEIVED
District Health Office No. 10
District File Number 8148-1494
Date Filed AUG 23 1948

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 *Fred J Karle*

Licensed Embalmer No. 1023

P. O. Address. *Kohoto 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.