

FILED DEC 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. Musick  
State File No. 36959

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>5465</u>		Registrar's No. <u>1079</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Springfield</u> ) c. LENGTH OF STAY (in this place) <u>48 yrs</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>N. Campbell Twp 2516 W. Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u> d. STREET ADDRESS (If rural, give location) <u>2511 State</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>August</u> b. (Middle) <u>Carlson</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 7, 1949</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 16 1863</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter Shop</u>	11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13a. FATHER'S NAME <u>Gus Carlson</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Acland</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Marold E. Carlson Springfield, Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage, Cerebral</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  INTERVAL BETWEEN ONSET AND DEATH <u>331X</u>						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Hemorrhage, cerebral</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>11.14.1949</u> , to <u>12.7.</u> , 1949, that I last saw the deceased alive on <u>12-7</u> , 1949, and that death occurred at <u>9:45p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Dr. Musick</u>			23b. ADDRESS <u>542-52 Med. Arts Bldg. Springfield, Mo.</u>		23c. DATE SIGNED <u>12.8.49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12/10/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Swedish Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Mt. Grove, Mo.</u>				
DATE REC'D BY LOCAL <u>12-9-49</u>	REGISTRAR'S SIGNATURE <u>W.E. Handley</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo.</u>				

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed William Greer.....

Signed.....

Student Embalmer

Licensed Embalmer No. 4733.....

P. O. Address Springfield, 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.