

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24479

State File No.

FILED JUL 20 1953

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 656

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Barry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield,</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>	
c. LENGTH OF STAY (in this place) <u>1 month</u>		d. STREET ADDRESS (If rural, give location) <u>Route 1, Eureka Springs, Ark.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Magnus</u>		b. (Middle) _____ c. (Last) <u>Wold</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>July 14, 1953</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 7, 1891</u>
9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>On Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Luverne, Minn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Martin Wold</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Grace Wold</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>358-03-2379</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Grace Wold</u>		ADDRESS <u>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, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malnutrition</u> ANTECEDENT CAUSES <u>Deferred pending autopsy report</u> 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.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>6-15, 1953</u> to <u>7-14, 1953</u> that I last saw the deceased alive on <u>7-13, 1953</u> , and that death occurred at <u>4:01 a. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u> Homer C. Marshall, M.D.</u>		23b. ADDRESS <u>Springfield, Mo.</u>	
23c. DATE SIGNED <u>7-14-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>July 15, 1953</u>	
24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Luverne, Minnesota</u>	
DATE REC'D BY LOCAL REG. <u>7-14-53</u>		REGISTRAR'S SIGNATURE <u>Earl Williamson</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Gorman-Scharpf Funeral Home, Inc.</u>		ADDRESS <u>Springfield, Missouri</u>	

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

SEP 1 4 1954

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.

Student
Student Embalmer

Signed L. A. Gorman

Licensed Embalmer No. 3177

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.