

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000350
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 86

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph <i>c117</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hosp.		Length of stay in lb 65 years	d. STREET ADDRESS (If outside, give location) 1009 1/2 Frederick Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Halvor Amondis Skoglund			4. DATE OF DEATH Month Day Year Jan. 20, 1959		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1888	9. AGE (In years last birthday) 70	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Hosp. Attendant	10b. KIND OF BUSINESS OR INDUSTRY State Hosp.	11. BIRTHPLACE (City and state or country) Brandford, Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Nils Skoglund	13b. MOTHER'S MAIDEN NAME Lovesa Anderson	14. NAME OF HUSBAND OR WIFE Anna A. S'oglund
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes Mexican war	16. SOCIAL SECURITY NO. 491-10-8550	17. INFORMANT Mrs. Anna Skoglund, 1009 1/2 Frederick, St. Joseph
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma epidermoid of larynx primary</i> <i>Retrol Salivary Adenocarcinoma grade 2 primary</i> <i>2 metastases to spine</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>aggravated 7 mo</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>161X</i>		INTERVAL BETWEEN ONSET AND DEATH NO
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20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <i>Sept 20, 1955</i> to <i>Jan 20, 1959</i> and last saw him alive on <i>1-20-59</i> Death occurred at <i>6:15p.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Wm B. Rost MD</i> (Degree or title)	22b. ADDRESS <i>316 North St Joseph Mo</i>	22c. DATE SIGNED <i>1-23 59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	23b. DATE <i>1/23/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ashland Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Joseph Missouri</i>
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24. FUNERAL DIRECTOR <i>Heston-Bowman</i> ADDRESS <i>St. Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Jan. 27, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Standell</i>
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MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.
Dr. Wm. B. Rost

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
Signature of Student Embalmer

Signed *William J. Galbraith*
Licensed Embalmer No. *45-25*
P. O. Address... *St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.