

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040471

STATE FILE NUMBER

Registration District No. 74 Primary Registration District No. 4137 Registrar's No. 49

FILED DEC 4 1961

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Trimble</u>		c. CITY OR TOWN <u>Trimble</u>	
Length of stay in 1b <u>15 Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>No Street Address</u>		d. STREET ADDRESS (If outside, give location) <u>No Street Address</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Sigfrieda</u> Middle <u>Eunice</u> Last <u>Holmgren</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1889</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (City and state or country) <u>Gateborg, Sweden</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Johann Johansson</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		
14. NAME OF HUSBAND OR WIFE <u>John Holmgren</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. _____		
17. INFORMANT <u>J. Ed. Holmgren</u>		Address <u>Trimble Mo.</u>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>3 yr</u>
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>		
DUE TO (b) <u>Carcinoma Rt. Breast</u>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____	
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 _____

21. I attended the deceased from Jan 1958 to Nov 27, 1961 and last saw her alive on Nov 26, 1961
Death occurred at 11¹⁰ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>David R. Charles M.D.</u>		22b. ADDRESS <u>Smithville, Mo</u>		22c. DATE SIGNED <u>11-28-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dell Rapids</u>		23d. LOCATION (City, town, or county) (State) <u>Dell Rapids South Dakota</u>
24. FUNERAL DIRECTOR <u>Clarence E. Hixson</u>		ADDRESS <u>Gower Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-28-1961</u>
		26. REGISTRAR'S SIGNATURE <u>Mary W Searee</u>		

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence E. Hipson

Licensed Embalmer No. 5122

P. O. Address Lower, 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.