

S. No. 2  
M-5-43  
5-17-39  
I X36671

FILED AUG 12 1947  
Registration District No. 21947

Primary Registration District No. 6019

State File No. \_\_\_\_\_  
Registrar's No. 24

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural Orrick  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community Forty Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray

(c) City or town Rural 1 Mi. n-e Orrick  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME August P. Sandstrom

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24  
year 1947 hour 1 minute 15 A.M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nina Sandstrom 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Aug 20 1878  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

68	10	4	_____ hr. _____ min.
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Immediate cause of death Coronary Thrombosis of Duration \_\_\_\_\_

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

10. Usual occupation Farmer

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

12. Name John Sandstrom

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

14. Maiden name Unknown

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

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Nina Sandstrom

(b) Address Orrick, Mo.

17. (a) Burial (b) Date thereof 6-25-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation South Point

18. (a) Signature of funeral director B. W. Good

(b) Address Orrick, Mo.

19. (a) 6/25/47 (b) Helen J. Larkins  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

23. Signature John F. Baber  
Address Richmond 270 Date signed 6-24-47

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury Coroner

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 8-8-47

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 Victor E. Imminger

Licensed Embalmer No. 2896

P. O. Address Liberty 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.**