STATE OF FLORIDA

BUREAU OF VITAL STATISTICS

STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

File No. 2372

Registered No. 3

[If death occurred in a hospital or institution, give its NAME instead of street and number]

1 PLACE OF DEATH

County Lake

Precinct Groveland (Write name, not number)

or Inc. Town .....

or City .....

Registration District No. 2409

Primary Registration Dist. No. 24237

(No. ..... St.; ..... Ward)

2 FULL NAME Andrew Halmgren

(a) Residence. No. ..... St., ... Ward, ...

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed or Divorced (Write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH: Oct. (Month) 11 (Day) 1844 (Year)

7 AGE: 80 yrs. 3 mos. 24 ds. IF LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Sweden

10 NAME OF FATHER: Adolph Halmgren

11 BIRTHPLACE OF FATHER (City or Town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Christine

13 BIRTHPLACE OF MOTHER (City or Town) (State or country): Sweden

14 Informant (Address): Fritz Halmgren

15 Filed Feb 5 1925 Mae B. Linton Registrar.

Form V. S. No. 4

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year): Feb 4th 1925

17 I HEREBY CERTIFY, That I attended deceased from 2-2-25, 1925, to 2-4-, 1925, that I last saw him alive on February 4th, 1925, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction (Acute)

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. H. Dixon M.D., M. D.

19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.) 115

19 Place of Burial, Cremation, or Removal: Oakdale Ill

Date of Burial or Removal: Feb-6 1925

20 UNDERTAKER: L. C. Page

ADDRESS: Leesburg Fla.

plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.