

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

9004

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Raw Primary Registration District No. 1007  
 City Kansas City (No. K.C. General Hosp.) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 1177  
 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 2514 Charlotte St. Ward B  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 7 1867

7. AGE: YEARS 61 MONTHS 2 DAYS 8 If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Sweden  
 (STATE OR COUNTRY)

10. NAME OF FATHER Andrew Erickson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sweden  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Nelson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sweden  
 (STATE OR COUNTRY)

14. INFORMANT Reverend Clerk  
 (Address) K.C. Genl. Hosp.

15. FILED 3/16 28 1928 M. M. Casper REGISTRAR  
Asan

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-15 1928

17. I HEREBY CERTIFY That I attended deceased from 3-13 1928 to 3-15 1928  
 that I last saw her alive on 3-15 1928, and that death occurred, on the date stated above, at 2:00 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinoma of splenic flexure of colon  
12263 (duration) yrs. mos. da.

CONTRIBUTORY Intestinal obstruction (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED H.P.  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3-14 28

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) P. O. Willoughby, M. D.

3-15 1928 (Address) Subt K.C. Genl Hosp

\*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL 3-17 1928

20. UNDERTAKER Mr. E. J. Foster ADDRESS F. C. Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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