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

Do not use this space.

6640

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. B

Township Kaw — Primary Registration District No. 1002 — Registered No. 805

City Kansas City (No. Trinity Luthern Hosp. St. Ward)

2. FULL NAME Algot G. Erickson

(a) Residence. No. 4166 State Line St., 7 Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? 22 yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| Male | Wh. | Married. |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hillive O.Erikson.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb.14.1886

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ...min. |
|---|---|---|---|---|
| | 43 | 0 | 3 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stome-mason 26

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

(c) Name of employer K.C.Star.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden. 24

PARENTS

10. NAME OF FATHER Trulo Erickson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden. 24

12. MAIDEN NAME OF MOTHER No-record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden. 24

14. INFORMANT Hillive O.Erickson (Address) 4166 State line

15. FILED 2-18, 1929 [signature] Registrar

## MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 17 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-15, 1929, to 2-17, 1929 that I last saw him alive on 2-17, 1929, and that death occurred, on the date stated above, at 6:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

[illegible]

10A Right Side

92A

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Mitral Insufficiency

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1010

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [signature], M.D

2-18, 1929 (Address) 5/3 [illegible]

*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 Mt. Washington — DATE OF BURIAL 2/19/ 1929

20. UNDERTAKER H.W.Gates — ADDRESS K.C.Ks.

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.