

REC'D AUG 8 1938

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

24520

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Jackson Primary Registration District No. 1002  
(c) City Kansas City (d) Street No. KC Gen Hosp Registered No. 3025  
(e) Length of residence in city or town where death occurred yrs. mos. d. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. Bellevue Island St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-22-1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
60 10 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salver  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER 13. NAME Nelson

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Reina Clark (ADDRESS) KC Gen Hosp 7cc mo

18. BURIAL, CREMATION, OR REMOVAL Bellevue Island DATE 7-28-38

19. FUNERAL DIRECTOR John B. Tapscott (ADDRESS) 36 Campbell St

20. FILED July 28, 1938 M. M. Grove Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-20 .19 38

22. I HEREBY CERTIFY, That I attended deceased from 7-18, 1938, to 7-20, 1938

I last saw him alive on 7-20, 1938 Death is said

to have occurred on the date stated above, at 8:35 am

The principal cause of death and related causes of importance were as follows:

Cerebral Tubercu-  
losis; Embolism Date of onset

Other contributory causes of importance: 23

Name of operation Autopsy Date of Yes  
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following  
Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify O. J. De Maria M.D.

(Signed) S. M. K. C. Gen Hosp 7cc mo M. D.

(Address) S. M. K. C. Gen Hosp 7cc mo

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**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con  
with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**



