

REC'D FEB 20 1939

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

1376  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Kaw Primary Registration District No. 1002  
(c) City Kansas City (d) Street No. 4603 Genesee Registered No. 389  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 642 Carl Axel Carlson

(a) Residence, No. 4603 Genesee St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 13, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
75 10 17

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. Retired  
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) Sweden

FATHER 13. NAME Carl Nilson

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 (ADDRESS) Mrs. Gus Nilson  
4603 Genesee

## 18. BURIAL, CREMATION, OR REMOVAL

PLACE Forest Hill DATE Feb. 1, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gates Funeral Home  
Kansas City, Kansas

20. FILED Jan 30, 1939 Dr. R. C. Browne  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1936 to Jan 30, 1939  
I first saw him alive on Jan 18, 1922. Death is said to have occurred on the date stated above, at 9 a. m.

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

Cerebral Thrombosis

Date of onset

June 30

Other contributory causes of importance:

Arteriosclerosis  
Myocarditis10 yrs.  
1 yr.

Name of operation..... Date of.....

What test confirmed diagnosis? Physic Was there an autopsy? No

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? No

If so, specify.....

(Signed) Carl U. Lundquist, M. D.(Address) 704 P. & 2nd Bldg.  
K.C. Mo.

Dr. Carl N. Linquist

10620.14 - 3130

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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 comply with the above constitutes grounds for revocation of license.)**

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