

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

9337  
Do not use this space.

REC'D APR 17 1939

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 399  
 (b) Township Raw Primary Registration District No. 002 Registered No. 943  
 (c) City Jackson City (d) Street No. Trinity Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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**

(a) Residence, No. 2612 Cypress 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 20 - 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
46 9 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Bookkeeper  
 9. Industry or business in which work was done, as saw mill, bank, etc. Atlas Book Co  
 10. Date deceased last worked at this occupation (month and year) 1938 11. Total years spent in this occupation 108

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K. C. Mo

FATHER 13. NAME John Erickson

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 (NAME) (ADDRESS) Mrs Ellen M Erickson  
2612 Cypress

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Mt Moriah Nov. 2, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) M. Newcomer's Sons  
Brushcreek & Paseo.

20. FILED 3-2 1939 M. M. Erwin  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 1, 1939

22. I HEREBY CERTIFY That I attended deceased from Feb. 17, 1939, to March 1, 1939  
 I last saw him alive on Feb. 28, 1939. Death is said to have occurred on the date stated above, at 12:57 A.

The principal cause of death and related causes of importance were as follows:  
Lobar Pneumonia Date of onset 2-21-39  
Hemolytic Jaundice 2-21-39

Other contributory causes of importance:  
Hemolytic Jaundice 2-21-39

Name of operation none Date of             
 What test confirmed diagnosis? Epan. 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) Eugene H. Ferguson, M. D.  
 (Address) 933 Broadway

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.

WHILE CARRIED WITH UNWRAPPING TINKER—THIS IS A PERMANENT RECORD

1 X14023

Tracy B. King  
01/16/20

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

*Will Carr*

Licensed Embalmer No. 3976

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.**