

Registration District No. **7911** Primary Registration District No. **1003** Registrar's No. **2929**

I. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City** **NR**
(If outside city or town limits, write "RURAL")
(d) Street No. **664 West 70th. St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Elizabeth Erickson**
(b) If veteran, name war **No.** (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Earl** 6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **Oct. 12 1898**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 5 17 hr. min.

9. Birthplace **Lafayette Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John Cartson**

13. Birthplace **Lafayette Co. Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Maggie Marshall**

15. Birthplace **Lafayette Co. Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Earl Erickson**

(b) Address **Kansas City, Mo.**

17. (a) **Removal** (b) Date thereof **3-30-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Lexington, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **MAR 20 1940** (Date received for registration) **J. W. ...** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **29** year **1940** hour **5** minute **40** A. M.

21. I hereby certify that I attended the deceased from **3/20-40**, 19____, to **3/29-**, 19**40**
that I last saw h. **E.** alive on **3/29-40**, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: **Tuberculous meningitis**
Tuberculous meningitis
Due to **E.**

Other conditions: **Ship - left worms**
(Include pregnancy within 3 months of death)
Embryonic - Ship

Major findings: _____
Of operations: _____
Of autopsy: **DD**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature **R. K. Andrews** (M. D. or other) _____
Address **4932 ...** Date signed **3/29**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Albert W. Kappé

Licensed Embalmer No.

1861

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.