No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1171

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 131

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3419 Olive Street-2nd Floor North
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---- (Specify whether years, months or days) 1

In this community: 35 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City 3 8
(If outside city or town limits, write "RURAL")

(d) Street No.: 3419 Olive Street-2nd Fl. North
(If rural, give location) 0

(e) If foreign born, how long in U. S. A.? 57 years.

3. (a) PRINT FULL NAME: Mrs. Carrie Holmgren Walters

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Mr. John Walters

6. (c) Age of husband or wife if alive: ---- years

7. Birth date of deceased: September (Month) 10 (Day) 1852 (Year)

8. AGE: Years 88 Months 3 Days 27 If less than one day ____ hr. ____ min.

9. Birthplace: (City, town, or county) Sweden 4 (State or foreign country)

10. Usual occupation: At Home

11. Industry or business: ----

FATHER
12. Name: Unknown Holmgren
13. Birthplace: (City, town, or county) Sweden 4 (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: (City, town, or county) Sweden 4 (State or foreign country)

16. (a) Informant: Edith V. Walters
(b) Address: 3419 Olive KC Mo

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof: Jan. 11, 1941 (Month) (Day) (Year)

(c) Place of burial or cremation: D. W. Newcomer's Sons

18. (a) Signature of funeral director: D. W. Newcomer's Sons
(b) Address: 1401 Brush Creek Blvd.

19. (a) Jan 9, 1941 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 7th year 1941 hour 11 minute 05 P. M.

21. I hereby certify that I attended the deceased from 1-6, 1941, to 1-7, 1941; that I last saw her alive on 1-7, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	38 hrs.
Due to: Hypertension	
Due to: Arteriosclerosis	
Other conditions (Include pregnancy within 3 months of death) 83.0	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury: 3

23. Signature: L. James Larimore (M. D. or other) D.O.
Address: 1010 Chambers Bldg. Date signed 1-7-41

(Licensed Embalmer's Statement on Reverse Side)

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address K.C. Mo

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

If this body is not embalmed, fact should be so stated above.