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FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1425

Registration District No. 375 Primary Registration District No. 1002 Registrar's No. 385

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

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: Trinity Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 25 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 3236 Morrell Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Miss Segre Erickson

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: ____

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

7. Birth date of deceased: January 8, 1877 (Month) (Day) (Year)

8. AGE: Years 64 Months 0 Days 18 If less than one day ____ hr. ____ min.

9. Birthplace: Mead, Nebraska (City, town, or county) 1 (State or foreign country)

10. Usual occupation: At Home

11. Industry or business: ____

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

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

16. (a) Informant: Mrs. Anna Johnson
(b) Address: 3236 Morrell Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 28 '41 (Month) (Day) (Year)
(c) Place: burial or cremation: Green Lawn

18. (a) Signature of funeral director: Freeman Mortuary
(b) Address: 104 West 42nd street

19. (a) Jan 27 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26 year 1941 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from 1-11, 1941, to 1-26, 1941; that I last saw him alive on 1-25, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Intest. Obstruction partial — Duration: 1 mo.?
Due to: Carcinoma of Stomach — 1 yr.?
Due to: ____
Other conditions (Include pregnancy within 3 months of death): ____

Major findings: Of operations: Ca Stomach
Of autopsy: Same as above.

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: ____

23. Signature: J. A. Hill M. D. (M. D. or other)
Address: Trinity Hospital Date signed 1-26-41

(Licensed Embalmer's Statement on Reverse Side) for M. B. Casebolt, M. D.

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 Clarence W Chiles

Licensed Embalmer No. 3473

P. O. Address 76 CMCO.

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.