

FILLED AUG 16 1941 999  
Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(c) Name of hospital or institution: **Lakeside Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 weeks**  
In this community **2 weeks** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Carl W. Cederberg**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

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

6. (b) Name of husband or wife **Edith Cederberg** 6. (c) Age of husband or wife if alive **44** years

7. Birth date of deceased **December 15 1893**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**47 7 13** hr. min.

9. Birthplace **Iowa**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Owner**

11. Industry or business **Employment Service**

MOTHER FATHER { 12. Name **S. P. Cederberg**  
13. Birthplace **Sweden** (City, town, or county) (State or foreign country)  
14. Maiden name **Augusta Johnson**  
15. Birthplace **Sweden** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Edith Cederberg**

(b) Address **Hollywood, California**

17. (a) **Burial** (b) Date thereof **7-30-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill Cem**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **7-29-41** (b) **M. M. Crow**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **California**, (b) County **04**  
(c) City or town **Hollywood**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1376 Ridgewood Place**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? **X** **2** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **28th**, year **1941** hour **9:05** minute **A.** M.

21. I hereby certify that I attended the deceased from **July 11th** to **July 25th**, 19**41**, and that death occurred on the date and hour stated above.

Immediate cause of death **Asbestosis (Tubercular) et al. by asbestosis** Duration **4 mos.**  
Due to **chronic pulmonary tuberculosis - et** **30 yrs**  
Due to **chronic intestinal tuberculosis** **15 yrs**  
Other conditions **Chronic Nephritis** **?**  
(Include pregnancy within 3 months of death)

Major findings: **370** PHYSICIAN **—**  
Of operations: **370**  
Of autopsy: **370**  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **M. M. Crow** (M. D. or other) **0**  
Address **612 Chandler Bldg** Date signed **7/29/41**

Dr. Linville,

*Chilmark 12/24/1904*

**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 *E. M. Plank*

Licensed Embalmer No. *1848*

P. O. Address *71. C. Mo.*

**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.**