

No. 2
4-13-40
5-17-40
PI

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40783

State File No. _____

Registrar's No. 1458

Registration District No. 399

Primary Registration District No. 1002

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 Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Month 23 Days
(Specify whether years, months or days)
In this community 36 Years 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048
(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")
(d) Street No. 3205 East 26th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 36 10 years.

3. (a) PRINT FULL NAME Hilda Elizabeth Hellstrom Carlson

(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

(b) Name of husband or wife Victor Carlson 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased October 9 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 1 19 hr. min.

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

10. Usual occupation At Home

11. Industry or business Housewife

12. Name Franz Hellstrom

13. Birthplace Sweden
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Victor Carlson

(b) Address 3205 E 26

17. (a) Burial (b) Date thereof Dec. 1, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director D. V. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 10/1/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28th
year 1941 hour 6 minute 30 P. A. M.

21. I hereby certify that I attended the deceased from Oct. 5, 1941
1941, to Nov. 28, 1941;
that I last saw her alive on Nov. 28, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration 10-10-41

Due to Hypertension

Due to _____

Other conditions Subarachnoid fracture of femur 10-5-41
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____ 123
(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 John H. Stewart M.D. (M. D. or other) W.
Address 6348 Indiana Ave Date signed 11-29-41

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

48
3
8

MOTHER FATHER

3:54 PM
2-18
Juliana - in case

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 *A. C. Newcomer Jr.*

Licensed Embalmer No. 4043

P. O. Address *N. C. Mo.*

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.
Registrar's No. 4458

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County
(b) City or town
(c) Name of hospital or institution: Research Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Helda E. Carlson

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

4. Sex FE 5. Color or race 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.
61

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Jan 24/47 (b) H. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. 3205 626th St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

20. DATE OF DEATH: Month 11 day 28
year hour minute M.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death
Due to 186a 186a

Due to 18

Other conditions (include pregnancy within a month of death) Intra trochanteric fracture of femur

Major findings: Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 123
(b) Date of occurrence 10-5-1947

(c) Where did injury occur? Kansas City, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In driveway to daughter's home.
While at work? No (Specify type of place) (e) Years of injury Fall

23. Signature John R. Lewis, M.D. (M. D. or other)
Address 3048 Stearns Date signed 1-23-47

SUPPLEMENTARY

MOTHER FATHER

Duration
10-5-47
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-40783