V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1944

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 6183

Registrar's No. 643

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~~: Marth East O Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 4 days (Specify whether
In this community 48 years
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. 3617 East 27th Street 8
(If rural, give location)

(e) Citizen of foreign country? YES (Yes or No)

If yes, name country SWEDEN 1

3. (a) PRINT FULL NAME MRS. ALMA C. LARSON

3. (b) If veteran, name war No

3. (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~~ Mr. Victor Larson

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased October (Month) 14 (Day) 1877 (Year)

8. AGE: Years 66 Months 3 Days 21 If less than one day ..... hr. ..... min.

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

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Daniel Shonquist
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 MR. VICTOR LARSON
(b) Address 3617 EAST 27TH STREET

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8 1944 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Forest Hill Cemetery

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

19. (a) 2-8-44 (Date received local registrar) (b) D. C. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 5th
year 1944 hour 10 minute 25 P.M.

21. I hereby certify that I attended the deceased from January 7, 1944, to February 5, 1944; that I last saw her alive on February 3, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis & Cardiac insufficiency	9 Weeks
Due to Diabetes Mellitus & Cardio-Vascular renal Syndrome	4 years
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 61
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

23. Signature Gm G. Thompson (M. D. or other) DO
Address 3800 E 27 Acme Date signed 2-7-44

(Licensed Embalmer's Statement on Reverse Side)

DR. WM. W. THOMPSON 1-5
3800 E. 27 - LI-2831
LI-4246

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC 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, fact should be so stated above.