

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED SEP 7 1944

Registration District No. _____ Primary Registration District No. **1002**

Registrar's No. **3389**

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

48
3
8

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 Lutheran Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 3 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Independence
(If outside city or town limits, write "RURAL")

(d) Street No. 1308 W. Van Horn
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ALINE MATTHEWS GUSTAFSON

3. (b) If veteran, name war no

3. (c) Social Security No. 689-24-1076

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Edwin Gustafson

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased January 23 1923
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>21</u>	<u>6</u>	<u>21</u>	_____ hr. _____ min.

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

10. Usual occupation Inspector

11. Industry or business Lake City Ordnance Plant

MOTHER FATHER

12. Name Samuel Matthews

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

14. Maiden name Unknown Unknown

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

16. (a) Informant Edwin Gustafson

(b) Address 1308 W. Van Horn, Indep. Mo.

17. (a) Burial & Removal (b) Date thereof 8-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fayette, Missouri

18. (a) Signature of funeral director George C. Carson

(b) Address Independence, Missouri

19. (a) 8-17-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 15
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Aug. 12 1944 to Aug. 14 1944
that I last saw her alive on Aug. 14 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Ectopic pregnancy, acute glomerulonephritis

Due to _____

Other conditions Bronchopneumonia
(Include pregnancy within 3 months of death)

Major findings: Ectopic pregnancy, with hemorrhage of autopsy, acute glomerulonephritis

Of operations _____

Of autopsy _____

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? _____

23. Signature E. N. Beahm (M. D. or other) M.D.
Address 302 Y. W. Anderson St. Date signed 8-17-44

Duration 3 mo.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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(Licensed Embalmer's Statement on Reverse Side)

Kansas City, Mo.

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

Floyd C. Carson

Licensed Embalmer No. *4199*

P. O. Address *Independence, 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.