S. No. 2
1—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30094

FILED OCT 2 1944

Registration District No. 949

Primary Registration District No. 1002

Registrar's No. 3810

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: 3907 E 9th Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---- (Specify whether

In this community 25 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 47 3 9

(c) City or town KANSAS CITY MO
(If outside city or town limits, write "RURAL")

(d) Street No. 3907 E 9th Street
(If rural, give location)

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

If yes, name country SWEDEN

3. (a) PRINT FULL NAME MISS ANNA KRISTINE ERICSON

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 SINGLE

6. (b) Name of husband or wife —

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

7. Birth date of deceased DECEMBER 2 - 1874
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
69	9	17	hr. min.

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

10. Usual occupation LADIES TAILOR

11. Industry or business OWN BUSINESS ALTMAN BLDG

FATHER
12. Name AARON ERICSON
13. Birthplace 4 SWEDEN
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARIA UNKNOWN
15. Birthplace 4 SWEDEN
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. GEORGE HENRY

(b) Address 3907 EAST 9TH STREET

17. (a) REMOVAL (b) Date thereof SEPT 22-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OSAGE CITY KANSAS

18. (a) Signature of funeral director D. H. Newcomer's Son

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 9-21-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19TH year 1944 hour 6 minute 45P M.

21. I hereby certify that I attended the deceased from 9/11, 1944 to 9/19, 1944 that I last saw her alive on 9/19/44, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia — Duration 8 da

Due to Acute upper respiratory infection

Due to 108

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Cardiac arythmia

Major findings:
Of operations none

Of autopsy none

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 D. D. Edgewood (M. D. or other)

Address 4800 Swanson Way Date signed 9/20/44

(Licensed Embalmer's Statement on Reverse Side)

1:40- 4:40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.