

S. No. 2
OM-5-43
v. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29575

FILED OCT 13 1945

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4088

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
709 Washington 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 709 Washington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Edward Carlson
3. (b) If veteran, name Do not know
3. (c) Social Security Do not know

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 3
year 1945 hour 3 minute 20 P.M.

4. Male 5. Color or White
6. (a) Single, widowed, married, divorced Do not know
6. (b) Name of husband or wife Do not know
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: _____ (Month) _____ (Day) 1860 (Year)

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.

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death Coronary Sclerosis
Due to arterio sclerosis

9. Birthplace Do not know (City, town, or county) _____ (State or foreign country) 9

Due to _____
Other conditions (include pregnancy within 3 months of death) 94a

10. Usual occupation _____

Major findings: _____
Of operations: _____

11. Industry or business _____

MOTHER FATHER { 12. Name Do not know
13. Birthplace (City, town, or county) _____ (State or foreign country) _____
14. Maiden name _____
15. Birthplace (City, town, or county) _____ (State or foreign country) _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Of autopsy no
Heston T. Inquist

16. (a) Informant Coroner Office
(b) Address Kansas City, Mo School
17. (a) School (b) Date thereof 10-5-45
(Burial, cremation, or removal) _____ (Month) _____ (Year)

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? _____

18. (a) Signature of funeral director Passantio Bros
(b) Address Kansas City, Mo
19. (a) 10-5-45 (b) Thalaine Holmes
(Date received local registrar) _____ (Registrar's signature)

While at work? _____ (Specify type of place) _____
(e) Means of injury _____
23. Signature James M. ... (M. D. or other) _____
Address 1824 Prof Alley Date signed 10-8-45

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

28
3
8

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 Francis Walter

Licensed Embalmer No. 2749

P. O. Address K. C. 9700

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.