

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32643**

FILED NOV 7 1945

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **4413**

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:
4459 Jefferson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community **50 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **4459 Jefferson**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CARL A. ECKERSON**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **491-20-0379**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mrs. Anna Eckerson** 6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **March 26th 1881**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	7	6	hr. _____ min.

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

10. Usual occupation **Delivery Service**

11. Industry or business _____

12. Name **Joseph Eckerson**

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 **Mrs. Anna Eckerson**

(b) Address **4459 Jefferson Street**

17. (a) **Burial** (b) Date thereof **10/29/1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mount Moriah Cemetery**

18. (a) Signature of funeral director **Freeman Mortuary & Chapel**

(b) Address **104 West 42nd Street**

19. (a) **10-27-45** (b) **M. A. Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **26th**
year **1945** hour **4:00** minute _____ P.M.

21. I hereby certify that I attended the deceased from **August 10** 19**45** to **October 26** 19**45**.
that I last saw him alive on **October 20** 19**45**.
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of liver**
Due to **unknown**

Due to _____
Other conditions: **468**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **H. O. Pallett** (M. D. or other) **M.D.**
Address **1132 Prof. Bldg. Ke.** Date signed **10/27/45**

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

18
3
8

1132 Prof BDDg

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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas City, 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.