

FILED JAN 27 1947

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **254**

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 **VINEYARD PARK HOSPITAL**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 DAYS**
 In this community **56 YEARS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **MRS. MATILDA SWANSON**

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 **WIDOWED**

(b) Name of husband or wife **MR. CHARLES A. SWANSON** 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased **SEPTEMBER 18 1866**
 (Month) (Day) (Year)

8. AGE: Years **86** Months **3** Days **28** If less than one day hr. min.

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

10. Usual occupation **AT HOME**

11. Industry or business

12. Name **PETER SWANSON**

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

14. Maiden name **KATHERINE MALMSON**

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

16. (a) Informant **MRS. BERTHA JERN**

(b) Address **1165 EAST 66th STREET**

17. (a) **BURIAL** (b) Date thereof **JAN 18 1947**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FOREST HILL CEMETERY**

18. (a) Signature of funeral director **Dr. Newcomb**

(b) Address **1401 BROOK CREEK BLVD**

19. (a) **1-18-47** (b) **Staldine Holmes**
 (Date received local registrar) (Registrar's signature)

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. **4215 BELL STREET**
 (If rural, give location)
 (e) Citizen of foreign country? **YES** (Yes or No)
 If yes, name country **SWEDEN**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JAN.** day **16TH**
 year **1947** hour **9** minute **00 P.** M.

21. I hereby certify that I attended the deceased from **Jan 10 1947** to **Jan 16 1947**
 that I last saw him alive on **Jan 16 1947**
 and that death occurred on the date and hour stated above

Immediate cause of death **Pulmonary edema** Duration **2 days**

Due to **Cardiac Insufficiency (Mitral Regurgitation)** 3 weeks

Due to **Chr. Rheumatism**
 Other conditions **Arteriosclerosis**
 (Include pregnancy within 3 months of death)

Major findings: Of operations **h 92 h**
 Of autopsy **h**
 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?

While at work? (Specify type of place) (e) Means of injury **(1)**

23. Signature **J. G. Hedden** (M. D. or other)
 Address **1747 922 holt** Date signed **1-17-47**

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

MOTHER FATHER

48
3
8
0

RC 140

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..... *Bernard L. Moran*
Licensed Embalmer No. *4250*
P. O. Address..... *A.C.M.*

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.