

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24161
Registrar's No. 3158

Registration District No. 147

Primary Registration District No. 1002

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: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
In this community 2 YEARS
years, months or days (Specify whether)

3. (a) PRINT FULL NAME ROBERT Carl Ericson
(b) If veteran, name war No
(c) Social Security No. 513-12-0076

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced DIVORCED
6. (b) Name of husband or wife MRS. MARGARET ERICSON
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased MAY 22 1868
(Month) (Day) (Year)

8. AGE: Years 79 Months 2 Days 3
If less than one day hr. min.

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

10. Usual occupation GARDENER-COST WORKER

11. Industry or business U.S. GOVT.-FT. RILEY, KAS.

12. Name CARL ERICSON

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

14. Maiden name CAROLINE UNKNOWN

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

16. (a) Informant MRS. C.W. STRATTON

(b) Address 511 WEST 39th STREET

17. (a) BURIAL (b) Date thereof JULY 28 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEMETERY

18. (a) Signature of funeral director O.H. Newcomer, Sore

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 7-28-47 (b) Heraldine 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. 511 W. 39
(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 July day 25
year 1947 hour 2 minute 50 A. M.

21. I hereby certify that I attended the deceased from
July 11 1947 to July 25 1947
that I last saw him alive on July 25 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
arteriosclerotic heart disease
Diabetes mellitus

Due to.....
Due to.....

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

Major findings:
Of operations.....

Of autopsy None

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? 0

While at work? (Specify type of place).....

(e) Means of injury.....

23. Signature Wm W. Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 7-25-47

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

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. Loran*

Licensed Embalmer No. *4250*

P. O. Address..... *DC 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.