

S. No. 300
M-10-47
v. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16550**
Registrar's No. **2038**

FILED MAY 22 1948, 49
Registration District No. _____

Primary Registration District No. **1002**

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

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 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
In this community **40 years**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson #8**
(c) City or town **Kansas City 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **2931 Forest 8**
(If rural, give location)
(e) Citizen of foreign country? **unknown 0** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **Elizabeth Swenson**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **11**
year **1948** hour **6** minute **30 P.M.**
21. I hereby certify that I attended the deceased from
May 8, 19**48**, to **May 11**, 19**48**,
that I last saw him alive on **May 11**, 19**48**,
and that death occurred on the date and hour stated above.

4. Sex **Female** / 5. Color or race **white**
6. (a) Single, widowed, married, divorced **Single 0**
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if
alive years
7. Birth date of deceased **October 29, 1881**
(Month) (Day) (Year)

Immediate cause of death **Cerebrovascular accident**
Duration

8. AGE: Years Months Days If less than one day
66 69 6 12 hr. min.

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

9. Birthplace **Sweden** **Sweden #**
(City, town, or county) (State or foreign country)
10. Usual occupation **Rooming house operator**

Other conditions **Fracture right tibia**
(Include pregnancy within 3 months of death)

11. Industry or business
12. Name **Carl Swensson**
13. Birthplace **Sweden #**
(City, town, or county) (State or foreign country)
14. Maiden name **Betty Nelson #**
15. Birthplace **Sweden #**
(City, town, or county) (State or foreign country)

Major findings:
Of operations **1860**
Of autopsy **None 18**
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Betty Swenson**
(b) Address **Macon Mo.**
17. (a) **Removal** (b) Date thereof **5/13/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New Cambria, Mo.**
18. (a) Signature of funeral director **Melody-McGilley-Eylar**
(b) Address **1800 Linwood Kansas City, Mo.**
19. (a) **5-12-48** (b) **Sheldine Holmes**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Accident**
(b) Date of occurrence **5-8-48 123**
(c) Where did injury occur? **K. C. Jackson, Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
At home
While at work? **No** (Specify type of place)
(e) Means of injury **Fall**
Signature **Wm W Hart** (M. D. or other) **WJH**
Address **Med. Dir. Gen'l Hosp.** Date signed **5-12-48**

Dr. Jansen

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 *Glen E. Heck*

Licensed Embalmer No. *4063*

P. O. Address *F.C. MD*

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.