

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8569

1010

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1010			
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Jackson 48					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 68 YES		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City					
d. FULL NAME OF HOSPITAL OR INSTITUTION: trinity Lutheran Hospital				d. STREET ADDRESS (If rural, give location) 3625 Wyoming					
3. NAME OF DECEASED (Type or Print) Anna		a. (First) Anna		b. (Middle) L.		c. (Last) Pierson			
4. DATE OF DEATH 3-2-49		(Month) (Day) (Year)							
5. SEX F /		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed		8. DATE OF BIRTH April 23, 1870			
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) SWEDEN 4		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13a. FATHER'S NAME CARL GUSTAFF		13b. MOTHER'S MAIDEN NAME MARIA KRISTINA		14. NAME OF HUSBAND OR WIFE John G. Pierson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Fred Pierson		ADDRESS 1207 Stratford Rd.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Thrombosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201				INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 24 hrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☒			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from March 1, 1949, to March 2, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE Carl N. Lindquist (Degree or title) Carl N. Lindquist M.D.				23b. ADDRESS 106 W 14th		23c. DATE SIGNED 3-2-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3/4/49		24c. NAME OF CEMETERY OR CREMATORY FOREST Hill		24d. LOCATION (City, town, or county) (State) K.C. MO			
DATE REC'D BY LOCAL REG. 34-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCURE		ADDRESS Kansas City, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

Carl Lindquist
106 W 14 St

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Robert H. Reed

Signed _____
Student Embalmer

Licensed Embalmer No. 3745

P. O. Address _____

K. C. Ho

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.