

FILED APR 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12605

48

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1670

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN K.C. Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hickman Mills	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital		d. STREET ADDRESS (If rural, give location) 8300 James A. Reed Rd.	

3. NAME OF DECEASED (Type or Print) ANNA			4. DATE OF DEATH (Month) (Day) (Year) 4-13-1949		
a. (First)	b. (Middle)	c. (Last) OSTRUM	5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 2-15-1885		9. AGE (In years last birthday) 64		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Ole Solberg		13b. MOTHER'S MAIDEN NAME Don't Know		14. NAME OF HUSBAND OR WIFE Nelse Ostrom - Wsby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Nels Ostrom, 8300 James A. Reed Rd.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach		II. OTHER SIGNIFICANT CONDITIONS 151x			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, 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 E.C.H. Schmidt		23b. ADDRESS St. Lukes Hospital		23c. DATE SIGNED 13 April 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-16-49		24c. NAME OF CEMETERY OR CREMATORY Floral Hills	
				24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	

DATE REC'D BY LOCAL REG. 4-15-49		REGISTRAR'S SIGNATURE Geraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Freeman Mortuary K.C. Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Walter H. Erwin.....

Licensed Embalmer No. 4352.....

P. O. Address Kennett 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.