

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44843

State File No.

FILED DEC 21 1953

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 229

0972
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall	
c. LENGTH OF STAY (In this place) 3 Weeks		d. STREET ADDRESS (If rural, give location) 223 N. Bell	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbon Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Swea	b. (Middle) Cecelia	c. (Last) Erickson	4. DATE OF DEATH (Month) (Day) (Year) Dec. 12 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 21-1887	9. AGE (In years) (last birthday) 66	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Hours 11	IF UNDER 60 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Salina, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Axel Malstrom	13b. MOTHER'S MAIDEN NAME Bothilda Petterson	14. NAME OF HUSBAND OR WIFE Oscar J. Erickson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Oscar J. Erickson-Marshall, Mo.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Kidney + Breast		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary edema.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) Marshall Saline Mo
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 1940 to 12-12, 1953, that I last saw the deceased alive on 12-12, 1953, and that death occurred at 4 1/2 m., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) John R. Lawrence M.D.	23b. ADDRESS Marshall, Mo	23c. DATE SIGNED 12-12-53.
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/15/53	24c. NAME OF CEMETERY OR CREMATORY Topsie cemetery	24d. LOCATION (City, town, or county) (State) Topsie - Kansas
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DATE REC'D BY LOCAL REG. Dec-14-1953	REGISTRAR'S SIGNATURE Clara T. Gray	25. FUNERAL DIRECTOR'S SIGNATURE J. Leslie Sumner	ADDRESS Marshall, Mo
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MAR 2 1954

VS

SEP 20 1960

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 J. Lealie Summy

Licensed Embalmer No. 3235

P. O. Address Marshall, 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.