

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33140**  
**4529**

FILED NOV 10 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Kansas City</b>		c. CITY OR TOWN <b>Merriam</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>2 Days</b>		f. STREET ADDRESS (If rural, give location) <b>7500 West 67th Street</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Trinity Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>GERDA</b>		b. (Middle) <b>C.</b>		c. (Last) <b>CARLSON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 20, 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>2-3-1876</b>		9. AGE (In years last birthday) <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	

13a. FATHER'S NAME <b>Carl Enarson</b>		13b. MOTHER'S MAIDEN NAME <b>Ingerd Johnson</b>		14. NAME OF HUSBAND OR WIFE <b>Fred H. Carlson</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Ethel Lund, Merriam, Kansas</b>	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Left Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10/18/55</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Arterio-sclerosis</b>			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>331X</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 7/1/48, 19  , to 10/20, 1955, that I last saw the deceased alive on 10/19, 1955, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J.W. Young M.D.</b>		23b. ADDRESS <b>1401 S. W. Blvd</b>		23c. DATE SIGNED <b>10/21/55</b>	
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24a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10-22-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>		24d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>	
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DATE REC'D BY LOCAL REG. <b>10-22-55</b>		REGISTRAR'S SIGNATURE <b>Neva Minshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Freeman Mortuary K. C. Mo.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

*Fr. J. M. P. O'Connell*

*1401 S.W. Blvd.*

*No. 0450*

*2-5*

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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.....  
Signature of Student Embalmer

Signed *Max W. Kirkendall*

Licensed Embalmer No. *463*

P. O. Address *K. C.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.