

FILED NOV 15 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH34277
STATE FILE NUMBER

4640

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

| | | | | | | | |
|--|------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) | | | |
| a. COUNTY JACKSON | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | a. STATE MISSOURI | | b. COUNTY JACKSON | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1310 EAST ARMOUR ELM ST NURSING HOME | | Length of stay in 1b 60 YEARS | | c. CITY OR TOWN KANSAS CITY | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LOWEY SWANSON | | | | 4. DATE OF DEATH Month Day Year OCT. 25-1956 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE-4-1871 | 9. AGE (In years last birthday) 85 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. | |
| 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 (City and state or country) SWEDEN | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME PETER WALLGREN | | | 14. MOTHER'S MAIDEN NAME CHRISTINE ANDERSON | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address MRS. EDITH WHEARETT 4309 HOLLY STREET KANSAS CITY, MO | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion | | | | | | | Immediate |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO (b) Coronary Atherosclerosis | | | | | | | |
| DUE TO (c) Generalized Arterio Sclerosis | | | | | | | 430 IF |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sickle Cell Anemia, Fracture of Femur | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| | | | Fell in Home - Fracture of Intertrochanteric Rt Femur - Jan - 15 - 1956 | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home | | |
| | | | 20f. CITY, TOWN, OR LOCATION Kansas City | | COUNTY Jackson | | STATE MO |
| 21. I attended the deceased from Jan - 16 - 56 to Oct - 25 - 56 and last saw her alive on Oct - 20 - 56 | | | | | | | |
| Death occurred at 8:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Carl H. Brust (Degree or title) D | | | | 22b. ADDRESS 106 W 14th St K.C. Mo | | 22c. DATE SIGNED Oct-26-56 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE OCT-27-1956 | 23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY | | 23d. LOCATION (City, town, or county) Kansas City | | STATE Missouri |
| 24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS | | ADDRESS 1331-BRUSH CREEK KANSAS CITY, MO. | | 25. DATE RECD. BY LOCAL REG. 10-26-56 | | 26. REGISTRAR'S SIGNATURE never minshall | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Carl H. Brust

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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-56

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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 *Chester K Brown*

Licensed Embalmer No. *4*

P. O. Address *KE*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.