

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 27 1956

41824

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 572

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>104 Truman line 3 weeks</u>				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>8607 Wilson rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mathilda</u> Middle <u>ERICKSON</u> Last <u>ERICKSON</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1862</u>	9. AGE (In years last birthday) <u>94</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (City and state or country) <u>Nora Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Erickson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Name) <u>John Erickson</u> Address <u>8607 Wilson rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>not known</u> <u>Several yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of hip - -</u>						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.) <u>fell getting from bed about 2 mos ago - treated</u>					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>  </u> <u>  </u> <u>  </u>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Jackson County Hosp until recently + moved to Independence Mo.</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Oct 6 - 56</u> to <u>  </u> and last saw her alive on <u>Oct 6 - 56</u> Death occurred at <u>Dec 17, 1956</u> at <u>  </u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Chase Nickerson M.D.</u>				22b. ADDRESS <u>10901 Winnie Indep. Mo</u>		22c. DATE SIGNED <u>12-18-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 19, 1956</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cemetery</u>		23d. LOCATION (City, town, & county) (State) <u>Kansas City Missouri</u>	
24. FUNERAL DIRECTOR <u>Island Speaks Independence Mo</u> ADDRESS <u>  </u>				25. DATE RECD. BY LOCAL REG. <u>12-19-56</u>		26. REGISTRAR'S SIGNATURE <u>Romer</u>	

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare, Public Service  
 300-56  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
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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 *Robert Kenneth Patterson*.....

Licensed Embalmer No. *469*

P. O. Address *Indy, Ind*

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.