

Health,  
Welfare  
Public  
Service

300  
-56

Use only black ink or ribbon typewrite if possible. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4794  
STATE FILE NUMBER  
561

FILED FEB 27 1957

Registration District No. 149 Primary Registration District 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>MISSOURI</b> b. COUNTY <b>JACKSON</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ELMS NURSING HOME</b>			Length of stay in bed <b>60 YEARS</b>		d. STREET ADDRESS <b>2841 ASKENE AVE 6310 EAST ARROW</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>C.</b> Last <b>JENSEN</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>3.</b> Year <b>1957</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 22 1879</b>		
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.		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 country) <b>OREGON ILLINOIS</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>CHARLES NYGREN</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTINE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MRS. HAZEL CARLISLE</b> Address <b>4926 JARBIE ST. KANSAS CITY MO.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							2	
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.)					
20c. TIME OF INJURY Hour - Month, Day, Year a. m. p. m.								
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 <b>Nov. 14, 1956</b> to <b>Feb. 3, 1957</b> and last saw her <sup>her</sup> <del>him</del> alive on <b>Jan 26, 1957</b> Death occurred at <b>12:10 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Don A. Black</b> (Degree or title)				22b. ADDRESS <b>M.D. 924 Professional Bldg.</b>		22c. DATE SIGNED <b>2/4/57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL 2-5-57</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL</b>		23d. LOCATION (City, town, or county) (State) <b>K.C. Mo</b>		
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS KANSAS CITY MO.</b>			ADDRESS <b>1331 BRUSH CREEK</b>		25. DATE RECD. BY LOCAL REG. <b>2-5-57</b>		26. REGISTRAR'S SIGNATURE <b>new Minshall</b>	

(Licensed Embalmer's Statement on Reverse Side)

**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 Ray*.....  
Licensed Embalmer No. 41

P. O. Address K. C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.