

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13102
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1791

FILED MAY 1 - 1957

300
1-57

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) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>748 TOWN Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4707 Charlotte</u>		Length of stay in lb <u>53 yrs.</u>	d. STREET ADDRESS <u>4707 Charlotte St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARL</u> First <u>EMANUEL</u> Middle <u>EKSTROM</u> Last			4. DATE OF DEATH <u>April-14-1957</u> Month Day Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 22, 1890</u>	9. AGE (In years last birthday) <u>77</u>	FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing & Heating</u>	11. BIRTHPLACE (City and state or country) <u>TOPEKA, KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Austruff Ekstrom</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF WIFE OR WIFE <u>Ida Ekstrom</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Ida Ekstrom</u>		Address <u>4707 Charlotte St K.C. Mo.</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>Cardiac Arrest</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerotic & Hypertensive Cardiovascular Disease</u>			10 Yrs. 4201	
DUE TO (c) _____					_____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a): <u>① Previous Myocardial Infarction ② Nephrosclerotic ③ Diabetes</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.)					
20c. TIME OF INJURY. Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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>1952</u> to <u>19 April 57</u> and last saw her alive on <u>March-1957</u> Death occurred at <u>11:45 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Philip G. Kaul</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>411 Nichols Rd.</u>		22c. DATE SIGNED <u>15 April 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>APR 17 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>		
24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons</u>		ADDRESS <u>331. Bross Cause K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-17-57</u>	26. REGISTRAR'S SIGNATURE <u>Reva Minshall</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

(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 *Chester K Brown*

Licensed Embalmer No. *4931*
P. O. Address *KC 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.