

Health, Welfare, Public Service

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31829
STATE FILE NUMBER 3864

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSPITAL		Length of stay in lb 27 YEARS	d. STREET ADDRESS (If outside, give location) 343 SOUTH LAWN AVE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) JOHN HARISTON EARICKSON			4. DATE OF DEATH August-15-1957		
First	Middle	Last	Month	Day	Year

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 17, 1908	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GATE GUARD	10b. KIND OF BUSINESS OR INDUSTRY H.C. POWER FLIGHT CO.	11. BIRTHPLACE (City and state or country) GLASGOW MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME KIRK S. EARICKSON	13b. MOTHER'S MAIDEN NAME MARY JANE HARISTON	14. NAME OF HUSBAND OR WIFE MARY EARICKSON
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 487-01-0192	17. INFORMANT MRS MARY EARICKSON Address 343 SOUTH LAWN AVE KANSAS CITY, MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTERIOR MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 18 HRS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE 5 YRS	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from AUG 1956 , to AUG 15, 1957 and last saw ^{her} him alive on AUG 15, 1957 Death occurred at 10.31 A. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) James W. Fowler M.D.	22b. ADDRESS 1103 GRAND AVE. KANSAS CITY, MO.	22c. DATE SIGNED AUG 16, 1957
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUG. 17, 1957	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON CEMETERY	23d. LOCATION (City, town, or county) (State) GLASGOW MISSOURI
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24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS ADDRESS 320 BAYBERRY KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 8-17-57	26. REGISTRAR'S SIGNATURE neva minshall
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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-57

STATEMENT BY LICENSED EMBALMER

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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.