

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31835

STATE FILE NUMBER

FILED SEP 24 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4189

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>Kansas City Mo</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) HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u> Length of stay in lb <u>13 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>209 Beulah Creek</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs Inez Mildred Engstrom</u> First Middle Last		4. DATE OF DEATH <u>9-6-1957</u> Month Day Year	
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>9-12-1896</u>
9. AGE (In years last birthday) <u>60</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Processor - Commodities Credit Corp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woodhull Illinois</u>	11. BIRTHPLACE (City and state or country) <u>U. S. A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Fredrick Sandquist</u>	
14. MOTHER'S MAIDEN NAME <u>Walgren</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>488-36-4512</u>		17. INFORMANT <u>Eduard Engstrom</u> Address <u>4736 W 77th St</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>Metastatic Cancer, generalized</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Primary cancer, site probably thyroid</u> DUE TO (c) <u>194x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>Pituitary necrosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>16 months</u> <u>194x</u>
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.)		20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year <u>  </u> a. m. <u>  </u> p. m. <u>  </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		20g. COUNTY	
20h. STATE		21. I attended the deceased from <u>May 1956</u> to <u>Sept. August 6, 1957</u> and last saw her alive on <u>9-6-57</u> Death occurred at <u>2:00 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>L. Harold Engstrom M.D.</u>		22b. ADDRESS <u>1226 Rialto Blvd</u>	
22c. DATE SIGNED <u>9-7-57</u>		23. NAME OF CEMETERY OR CREMATORY	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-7-57</u>	
23c. LOCATION (City, town, or county) <u>Woodhull, Illinois</u>		23d. (State)	
24. FUNERAL DIRECTOR ADDRESS <u>France-Worrell Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>9-7-57</u>	
26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Charles I. Cooper

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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 em-  
- by me, or by ....., Student Embalmer No. ....  
- working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Russell N. Fran* .....

Licensed Embalmer No. *42*

P. O. Address *K C* .....

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.