

Health,  
Welfare  
Public  
Service

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318337  
STATE FILE NUMBER  
3980

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>		c. CITY OR TOWN <b>Kansas City</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheram</b>		Length of stay in lb <b>56 Yrs.</b>	
e. d. STREET ADDRESS <b>1240 Washington</b>		(If outside, give location) <b>110</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMIL</b> Middle <b>A.</b> Last <b>ERICSON</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>24</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-1872</b>
9. AGE (In years last birthday) <b>85</b>		10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Former Owner K. C. Rug Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>4</b> <b>Nowrkoping, Sweden</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Jacob Ericson</b>		13b. MOTHER'S MAIDEN NAME <b>Clara Carlson</b>	
14. NAME OF HUSBAND OR WIFE <b>Elizabeth Ericson</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>500-12-7189</b>	
17. INFORMANT <b>Mrs. Elizabeth Ericson</b>		Address <b>K. C. 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>Prostatism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____			<b>610x</b>
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 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 _____ 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	
21. I attended the deceased from <b>14 July 1957</b> to <b>24 Aug -57</b> and last saw her alive on <b>23 Aug -57</b> Death occurred at <b>6 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Hjalmar E Carlson M.D.</b> (Degree or title)		22b. ADDRESS <b>1316 Professional Bldg.</b>	
22c. DATE SIGNED <b>24 Aug 1957</b>			
23a. BURIAL, CREMATION, REQUIVA (Specify) <b>Burial</b>		23b. DATE <b>8-26-57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>	
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b>		ADDRESS <b>K. C. Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>8-25-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minchall</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

KP  
2

1316 Prof. Bedy  
1:30 - 3:30

H. H. O. Carlson

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  .....

Licensed Embalmer No. 2939  
P. O. Address H. H. O. Carlson

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.