

Health,
, & Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34863

STATE FILE NUMBER

FILED OCT 21 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1094

S. 300
v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Euchanan | | 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 St. Joseph | | 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 Mo. Methodist Hosp. | | Length of stay in lb 1 Month | d. STREET ADDRESS (If outside, give location) 322 So. Oakley Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Bulah Middle P. Last Erickson | | | 4. DATE OF DEATH Month Oct. Day 12 Year 1957 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Dec. 24, 1902 |
| 9. AGE (In years last birthday) 54 | | IF UNDER 1 YEAR Months 5 Days 4 | IF UNDER 24 HRS. Hours 1 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk & Cashier | | 10b. KIND OF BUSINESS OR INDUSTRY Auto retail | 11. BIRTHPLACE (City and state or country) Decatur Co., Iowa |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME Norman Morgan | |
| 13b. MOTHER'S MAIDEN NAME Cora A. Brown | | 14. NAME OF HUSBAND OR WIFE Kenneth B. Erickson | |
| 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. 497-26-3402 | 17. INFORMANT Address Mrs. J.E. Watters, St. Joseph, Mo. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Valvular Heart Disease - Aortic Stenosis | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs + |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Arteriosclerosis General | | | 3 yrs + |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cirrhosis Portal - 4211 | | | 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 10-7-57 to 10-12-57 and last saw her alive on 10-12-57 Death occurred at 12:53 p. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE H. C. Stenne MD (Degree or title) | | 22b. ADDRESS 207 1/2 E. 8th Bldg. St. Joseph, Mo. | 22c. DATE SIGNED 10-14-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Oct. 14, 1957 | 23c. NAME OF CEMETERY OR CREMATORY Akron Cemetery | 23d. LOCATION (City, town, or county) (State) Akron, Missouri. |
| 24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc. St. Joseph, Mo. | | 25. DATE RECD. BY LOCAL REG. Oct. 16, 1957 | 26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton |

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

Student
Signature of Student Embalmer

Signed *Albert P. Hanning*

Licensed Embalmer No. 3258
P. O. Address..... St., Joseph, 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.