

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044271

STATE FILE NUMBER 5669

FILED DEC 18 1958

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

300  
1-57

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) KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RESEARCH HOSPITAL		Length of stay in 1b 40 YEARS	d. STREET ADDRESS (If outside, give location) 6635 WOODLAND AVENUE
3. NAME OF DECEASED (Type or print) First Middle Last AGNES LENA MAGNUSON			4. DATE OF DEATH Month Day Year NOV. 27, 1958
5. SEX FEMALE	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 JAN. 30, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (City and state or country) JONKOPING, SWEDEN
13a. FATHER'S NAME CARL ROBERT SODERSTROM		13b. MOTHER'S MAIDEN NAME JOHANNA AUGUSTA EK	14. NAME OF HUSBAND OR WIFE ERNEST MAGNUSON
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. NONE	17. INFORMANT Address WILLIAM R. MAGNUSON, 6705 CHERRY ST. K.C. 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) Acute coronary thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardio-vascular disease DUE TO (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			INTERVAL BETWEEN ONSET AND DEATH Approx 1-2 hrs
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 COUNTY STATE
21. I attended the deceased from 9-21-48 to 11-27-58 and last saw her alive on 11-27-58 Death occurred at 9:40 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Adrian J. Brown M.D.		(Degree or title)	22b. ADDRESS 4526 Paseo KC 10 Mo
22c. DATE SIGNED 11-28-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 1, 1958	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.V. NEWCOMER'S		25. DATE RECD. BY LOCAL REG. 12-1-58	26. REGISTRAR'S SIGNATURE New Marshall

MEDICAL CERTIFICATION  
Adrian J. Brown USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.



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 *Vern Sewer* .....

Licensed Embalmer No. *4915* .....  
P. O. Address *K O 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.