

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005686
STATE FILE NUMBER
491

FILED FEB 17 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</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>MERRIAM</u> 8150 E
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		Length of stay in 1b <u>24 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>8001 W. 52</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>L</u> Last <u>LARSON</u>			4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1959</u>		
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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>5/31/1899</u>	9. AGE (In years last birthday) <u>69</u>	10. FUNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, KANSAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>CHARLES GUSTAFSON</u>	13b. MOTHER'S MAIDEN NAME <u>MATILDA HOLQUIST</u>	14. NAME OF HUSBAND OR WIFE <u>MARTIN L. LARSON</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MRS. R. L. BIGLER, MERRIAM, Ks.</u>
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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) <u>Acute Myocardial Infarction due to</u> <u>Arteriosclerotic Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis, Diabetes Mellitus</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 _____ 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 _____
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21. I attended the deceased from Sept 1955 to Jan 24 1959 and last saw her alive on Jan 24 1959
Death occurred 1:10 P on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harold W. North, M.D.</u> (Degree or title)	22b. ADDRESS <u>201 Plaza Med Bldg, Kansas City, Mo.</u>	22c. DATE SIGNED / <u>Jan 24 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-26-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN</u>	23d. LOCATION (City, county, state) <u>KANSAS CITY, MO.</u>
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24. FUNERAL DIRECTOR <u>FREEMAN MORTUARY K.C. Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-26-59</u>	26. REGISTRAR'S SIGNATURE <u>Irlva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

Harold W. North USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

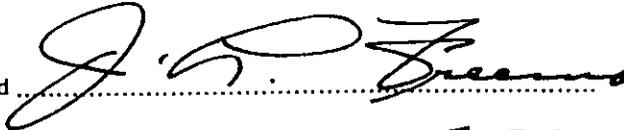
All diseases in Part I must be causally related.

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1-57

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 F. 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.