

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 29 1960 149

60-030474  
4198 STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             |                                                              |                                                                                       |                                           |                                                                                       |                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |                                           |                                                                                       |                                    |
| a. COUNTY<br><b>Ja ckson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                           | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br><b>Kansas City</b>                                                               |                                                              | Length of stay in lb<br><b>6 DAYS</b>                                                 |                                           | c. CITY OR TOWN<br><b>Raytown</b>                                                     |                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>Research Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                        |                                                              | d. STREET ADDRESS (If outside, give location)<br><b>7114 Evanston</b>                 |                                           | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                    |
| 3. NAME OF DECEASED (Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                              | 4. DATE OF DEATH                                                                      |                                           |                                                                                       |                                    |
| First<br><b>Cyrus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | Middle<br><b>O.</b>                                                                                                                                         |                                                              | Last<br><b>Carlson</b>                                                                |                                           | Month Day Year<br><b>August 13, 1960</b>                                              |                                    |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. COLOR OR RACE<br><b>White</b>                                                                          | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 4, 1893</b>                      | 9. AGE (last birthday)<br><b>67</b>                                                   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HR                                                                        |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Building Contractor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Contracting</b>                                                                                                     |                                                              | 11. BIRTHPLACE (City and state or country)<br><b>MINNEAPOLIS, MINN.</b>               |                                           | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S./A.</b>                                         |                                    |
| 13a. FATHER'S NAME<br><b>SWAN CARLSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             | 13b. MOTHER'S MAIDEN NAME<br><b>ELEONORA CARLINA ENGBERG</b> |                                                                                       |                                           | 14. NAME OF HUSBAND OR WIFE<br><b>Lillian Carlson</b>                                 |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>494-12-5944</b>                                                                                                               |                                                              | 17. INFORMANT<br><b>MRS. LILLIAN CARLSON, 7114 EVANSTON</b>                           |                                           |                                                                                       |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |                                                                                                           |                                                                                                                                                             |                                                              |                                                                                       |                                           | INTERVAL BETWEEN ONSET AND DEATH                                                      |                                    |
| 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<br>Hour a.m. p.m.<br>Month, Day, Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                              |                                                                                       |                                           |                                                                                       |                                    |
| 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 <b>August 8, 1960</b> to <b>August 13, 1960</b> and last saw him alive on <b>August 13, 1960</b><br>Death occurred at <b>8 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                              |                                                                                       |                                           |                                                                                       |                                    |
| 22a. SIGNATURE<br><b>Ira F. Smith MD</b> (Degree or title)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                              | 22b. ADDRESS<br><b>1109 Professional Bldg Kansas City Mo</b>                          |                                           |                                                                                       | 22c. DATE SIGNED<br><b>8/15/60</b> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 23b. DATE<br><b>AUG. 17, 1960</b>                                                                                                                           |                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FLORAL HILLS CEMETERY</b>                    |                                           | 23d. LOCATION (City, town, or county)<br><b>KANSAS CITY MISSOURI</b>                  |                                    |
| 24. FUNERAL DIRECTOR<br><b>D. W. NEWCOMER'S SONS</b> ADDRESS<br><b>1331 BRUSH CREEK KANSAS CITY, MO.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                             |                                                              | 25. DATE RECD. BY LOCAL REG.<br><b>8-16-60</b>                                        |                                           | 26. REGISTRAR'S SIGNATURE<br><b>H. L. Dwyer</b>                                       |                                    |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
**Ira F. Smith**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James W. Thorton

Licensed Embalmer No. 4889

P. O. Address 21. C. 770.

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.