

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19556

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City, Mo (No. Trinity Lutheran Hospital) St. _____ Ward _____

2. FULL NAME Miss Emelia C. Backstrom
 (a) Residence. No. 4403 Norledge Place St. 10 Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. _____
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 14, 1887

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>43</u>	<u>5</u>	<u>5</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Nurse
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Mo
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Gustaf A. Backstrom

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Sweden
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Christina Anderson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Sweden
 (STATE OR COUNTRY) _____

14. INFORMANT G. L. Backstrom
 (Address) 4403 Norledge Place

15. FILED 6/20/30 M. M. C. [unclear]
 REGISTRAR [unclear]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19th, 1930
 17. I HEREBY CERTIFY, That I attended deceased from Jan 1920 to June 19 1930
 that I last saw her alive on June 17, 1930, and that death occurred, on the date stated above, at _____ a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Inanition
 (duration)yrs. 8 mos. ds.
 CONTRIBUTORY Acetabular stenosis of
 (SECONDARY) Common bile duct.
 (duration)yrs. 18 mos. ds.

18. WHERE WAS DISEASE CONTRACTED [unclear]
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? yes DATE OF about 18 mos ago
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy findings
 (Signed) M. M. C. [unclear] M. D.
6/20/30 (Address) 929 Realto Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Elmwood Cemetery
 DATE OF BURIAL 6/21/30

20. UNDERTAKER Freeman Mortuary
 ADDRESS 104 W. 42nd St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

