

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

38577
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 100 Registered No. 4341
 (c) City Kansas City (d) Street No. Trinity Lutheran Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 525 Amanda Swanson

(a) Residence, No. 4325 Rainbow Blvd. St. K. C., Kansas
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 12, 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
78 4 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden 7

FATHER 13. NAME Carl John Carlson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden 7

MOTHER 15. MAIDEN NAME Christine Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

17. INFORMANT John Swanson
 (ADDRESS) 4325 Rainbow Blvd. K.C.K.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Memorial Park DATE 11-14-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gates Funeral Home
Kansas City, Kansas

20. FILED Nov 13, 1939 M. M. Cron
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 10, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1939, to Nov. 10, 1939

I last saw her alive on Nov. 10, 1939. Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:

Bilateral Hypostatic Pneumonia Date of onset 11-9-39
31

Other contributory causes of importance:
Chronic arteriosclerosis 1938?
nephritis
Chronic myocarditis

Name of operation none Date of ye
 What test confirmed diagnosis? autopsy Was there an autopsy? ye

23. If death was due to external causes (violence), fill in also the following:--
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Erwin H. Ferguson M. D.
 (Address) 933 Prof Blvd

E. H. Ferguson
Professional Body

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.....
....., Registered Apprentice No. *2810*
working under my personal supervision.

Signed *Harlyn Roe*
Licensed Embalmer No. *2810*
P. O. Address *Keosauqua City 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 this body is not embalmed, above space should be left blank.