

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

20731

State File No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2348

1. PLACE OF DEATH

(a) County Jackson  
(b) City or town K. C., Mo  
(c) Name of hospital or institution Trinity Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 day  
In this community 1 week  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County \_\_\_\_\_  
(c) City or town Salina Kansas  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? X \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

John P. Carlson  
JOHN P. CARLSON 142

3. (b) If veteran, name war N/O 8. (c) Social Security No. N/O

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8<sup>th</sup>  
year 1940 hour 7:50 minute P. M.

21. I hereby certify that I attended the deceased from noon  
June 8 - 1940, to 7:50 P.M. June 8, 1940  
that I last saw him alive on June 8<sup>th</sup> 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Stroke due to cerebral arteriosclerosis - with cancer of prostate as primary cause. Necrosis around anus and several places on buttocks.  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

4. Sex male 5. Color or race wht  
6. (a) Single, widowed, married, divorced 2  
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 9 years  
7. Birth date of deceased July 14 1884  
(Month) (Day) (Year)

8. AGE: Years 55 Months 10 Days 24  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation clerk

11. Industry or business \_\_\_\_\_

12. Name Owen August Carlson

13. Birthplace Sweeden  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Ryan Emanuel Horne

(b) Address SALINA, Kansas

17. (a) SALINA, K.S. (b) Date thereof 6-10-1940  
(Date of death, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salina, Mo.

18. (a) Signature of funeral director Stine-McClure

(b) Address K. C. 1720

19. (a) June 9, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Yes.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_  
23. Signature Geo. A. Roberts (M. D. or other) \_\_\_\_\_  
Address Professional Bldg Date signed 6-9-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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. ....

working under my personal supervision.

Signed

*H. Allen*

Licensed Embalmer No. *1413-*

P. O. Address *K. C. 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.**