

10. 2
13-40
17-39
X23159

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Trinity Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 Weeks**
(Specify whether years, months or days)
In this community **60 Years**

3. (a) PRINT FULL NAME **Mr. Charles E. Carlson**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife ----- 6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased **March 18 1862**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 5 19 hr. min.

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

10. Usual occupation **Builder**

11. Industry or business **and Real Estate**

12. Name **Oscar Carlson**

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

14. Maiden name **Anna Stromberg**

15. Birthplace **Sweden**
(City, town, or county) (State or foreign country)

16. (a) Informant **Oscar Carlson**

(b) Address **36th Blue Ridge**

17. (a) **Burial** (b) Date thereof -----
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **O. H. Newberry Son**

(b) Address **1401 Brush Creek Blvd.**

19. (a) **Sept. 9, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **36th & Blue Ridge Blvd.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **58** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **6th**
year **1940** hour **3** minute **50 A.** M.

21. I hereby certify that I attended the deceased from **Sept 3-40**
to **Sept 6 40**

that I last saw him alive on **Sept 5**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Branch pneumonia acute**

Due to **Hydro-nephrosis, Bilateral Chronic**

Due to **1940**

Other conditions **Prostatic Resection Trans-Ureth.**
(Include pregnancy within 3 months of death)

Major findings: **Prostatic Hypertrophy**

Of operations -----
Of autopsy **Yes**

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

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?

(Specify type of place)

While at work? ----- (e) Means of injury **1**

23. Signature **W. H. Newberry M.D.** (M. D. or other)
Address **1019 Park Blvd** Date **9/7/40**

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

MOTHER FATHER

10-3

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

Kenneth Page Sipp

Licensed Embalmer No. *41218*

P. O. Address *1309 Emul Creek Rd*

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, fact should be so stated above.