

JAN 8 1941
Registration District No. **999**

Primary Registration District No. **1002**

Registrar's No. **4980**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kan City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2834 Poplar
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 35 years
years, months or days)

3. (a) PRINT FULL NAME John Eklund

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Dec 17 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 8 hr. _____ min.

9. Birthplace Sweden (City, town, or county) (State or foreign country) 7

10. Usual occupation Labor 7

11. Industry or business _____

MOTHER FATHER { 12. Name J Eklund 7

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

14. Maiden name Unknown

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

16. (a) Informant Richard Eklund

(b) Address 2834 Poplar

17. (a) Green Lane Cem (b) Date thereof 12/30/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lane Cem

18. (a) Signature of funeral director Wm. Mayberry

(b) Address 2315 Linwood

19. (a) 12-30-40 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kan City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2834 Poplar
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-25-40 Day _____ Minute 6:50 M.
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Fibrous Myocarditis
Due to _____
Arteriosclerosis of Aorta
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature Russell (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Ray C. Snow
Licensed Embalmer No. 2560
P. O. Address 1807 Eubank 294

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.