

No. 2
4-12-40
5-17-39
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FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1342

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 382

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 Lutheran
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 57 years
(Specify whether years, months or days)

In this community 57 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Nellie H. Backstrom

3. (b) If veteran, name war No

3. (c) Social Security No. 495-09-8293

4. Sex Female

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 14, 1883
(Month) (Day) (Year)

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

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>10</u>	<u>6</u>	hr. _____ min.

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

10. Usual occupation Clerk

11. Industry or business _____

12. Name John D. Backstrom

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

14. Maiden name Caroline H. Erickson

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

16. (a) Informant Miss Alice J. Backstrom

(b) Address 1219 East 45th Street

17. (a) Burial (b) Date thereof 1-23-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 West 42nd Street

19. (a) Jan 21, 1941 (b) Dr. M. M. Crow
(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. 1219 East 45th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20
year 1941 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 14 - 1941
to Jan 20, 1941,
that I last saw her alive on Jan 20 - 1941, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death:

1-Acute pyelonephritis

2-Chronic vascular nephritis

Due to 3-Chronic hypertension

4-Chronic cystitis

Due to 5-multiple fibroids uterus (operated)

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

Duration 3 days

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Fibroids uterus

Of operations _____

Of autopsy above

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 b

23. Signature John J. ... (M. D. or other) _____

Address Trinity Hospital Date signed 1-23-41

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 *Clarence W. Childs*

Licensed Embalmer No. *3473*

P. O. Address *26 E. 7th St.*

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.