

No. 2  
4-13-40  
5-17-39  
I X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

5769

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

MAR 14 1943 95  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 541

48  
3  
8  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: K.C. General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Mo. & 3 days  
In this community unknown (Specify whether years, months or days)

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. 558 Main St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Andy Wengsten Wahlgren  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. unk

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 17th  
year 1941 hour 5 minut 50 P. M.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Div.  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: June 1 1865  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-14-40, 19\_\_\_\_, to 1-17-41, 19\_\_\_\_;  
that I last saw h. im alive on 1-17-41, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
75 7 16 hr. min.

Immediate cause of death: Arteriosclerotic gangrene left leg and foot; arteriosclerotic vascular disease

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

Due to \_\_\_\_\_  
Due to 97

10. Usual occupation None

Other conditions Acute pulmonary edema  
(Include pregnancy within 3 months of death)

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

MOTHER FATHER {  
12. Name No record 9  
13. Birthplace No record (City, town, or county) (State or foreign country)  
14. Maiden name No record  
15. Birthplace No record (City, town, or county) (State or foreign country) 9

Major findings: 97  
Of operations \_\_\_\_\_  
Of autopsy None

16. (a) Informant Record Clerk  
(b) Address K.C. Gen. Hospital, K.C. Mo.

22. If death was due to external causes, fill in the following:  
(e) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) Burial (b) Date thereof 2-7-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? \_\_\_\_\_

(c) Place: burial or cremation unknown

18. (a) Signature of funeral director Wm. A. ...  
(b) Address 121 Gen. Hospital  
19. (a) 2/6/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury 0  
23. Signature Dr. R. Thors (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K.C. Gen. Hospital, K.C. Mo. Date signed \_\_\_\_\_

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**