

No. 2  
-4-41  
17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED MAY 16 1941 MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13616

Registrar's No. 1597

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: K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
(Specify whether  
In this community 21 years  
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. 15 East 6th St.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22nd  
year 1941 hour 9 minute 60 P. M.  
21. I hereby certify that I attended the deceased from 4-15-41 19 to 4-22-41 19  
that I last saw him alive on 4-22-41 19  
and that death occurred on the date and hour stated above.

Immediate cause of death acute pulmonary congestion & edema  
Duration

Chronic myocarditis  
Due to 92 15  
Due to 92 15  
Other conditions (Include pregnancy within 3 months of death) 92 15

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy See above  
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? \_\_\_\_\_ Means of injury \_\_\_\_\_  
23. Signature Henry R. Jones (M. D. or other) 0  
Address Med. Dir. K.C. Gen. Hospital Date 4-22-41

3. (a) PRINT FULL NAME Albert Clauson

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M. 5. Color or race W. 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 June 6th 1886  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 10 16 hr. min.

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

10. Usual occupation None listed

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

12. Name Axel Clauson

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

14. Maiden name Mary Anderson

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

16. (a) Informant Record clerk

(b) Address K.C. Gen. Hospital, K.C. Mo.

17. (a) Removal (b) Date thereof 4-23-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Decorah, Iowa

18. (a) Signature of funeral director Decorah, Iowa

(b) Address Decorah, Iowa

19. (a) Apr 23 1941 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

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..... *Harry E. Jelley*

Licensed Embalmer No. *4078*

P. O. Address *Kansas City*

**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.**