No. 2
—1-4-41
5-17-39
I X26390

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

FILED JUN 10 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17188

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 850

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: 3535 Jefferson
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 3½ years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 3535 Jefferson 8
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Mrs. Botilda Hanson Trulson
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: May (Month) 6 (Day) 1857 (Year)

8. AGE: Years	Months	Days	If less than one day
84	0	4	____ hr. ____ min.

9. Birthplace: (City, town, or county) ____ Sweden (State or foreign country)
10. Usual occupation: At Home
11. Industry or business: ____
FATHER 12. Name: Carl Hanson
FATHER 13. Birthplace: (City, town, or county) ____ Sweden (State or foreign country)
MOTHER 14. Maiden name: Kjersta Truedson
MOTHER 15. Birthplace: (City, town, or county) ____ Sweden (State or foreign country)
16. (a) Informant: Mrs. O. W. Larson
(b) Address: 3535 Jefferson
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 5/10/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Lindsborg, Kansas.
18. (a) Signature of funeral director: R. V. Lindsey & Sons
(b) Address: 3811 Broadway
19. (a) May 11, 1941 (Date received by local registrar) (b) M. M. Crowell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10th year 1941 hour 10:00 AM minute ____ M.
21. I hereby certify that I attended the deceased from May, 1941 to May 10 1941 and that I last saw her alive on May 8th 1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Encephalomalacia	5 days
Due to: arteriosclerosis	10 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: 42 C
Of autopsy: ____

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: 0
23. Signature: Carl H. Lindquist M.D. (M. D. or other)
Address: 704 P. & S. Bldg. Date signed 5/10/41

(Licensed Embalmer's Statement on Reverse Side)

Dr. Carl Linquist
K.C. Power & Light
Call him again
@ 4 going down
Gr-0060

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 Leon J. Stewart

Licensed Embalmer No. 4177

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.