No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 1 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24049

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2588

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:
615 West 66th Terrace
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 7 Years 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 041

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 615 West 66th Terrace
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mr. Rainard Benedict Wahlquist

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Laura Dilley Wahlquist

6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased April (Month) 13 (Day) 1941 (Year) 1860

8. AGE:

Years	Months	Days	If less than one day
81	2	25	..... hr. ..... min.

9. Birthplace Gothenburg Sweden 4
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Newspaper Publisher

FATHER
12. Name Bengt Wahlquist
13. Birthplace ..... Sweden 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna Elizabeth Khalon
15. Birthplace ..... Sweden 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. F. R. Zacharias
(b) Address Enid Oklahoma

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 9, 1941
(Month) (Day) (Year)

(c) Place: burial or cremation Kewanee, Illinois

18. (a) Signature of funeral director D. W. Newcomb Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) 7/9/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1941 hour 10 minute 50 P.M.

21. I hereby certify that I attended the deceased from 1939
..... 19..... to ..... 19.....;
that I last saw him alive on July 8, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. myocarditis

Due to

Due to arterio-sclerosis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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

23. Signature Wm R. Jackson (M. D. or other)
Address 1107 Bryant Date signed 7/9/41

(Licensed Embalmer's Statement on Reverse Side)

Dr. D. R. Jackson
1107 Bryant Bldg
1230-430

[illegible]

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 C. Hervey Dusenberry

Licensed Embalmer No. 4070

P. O. Address K. C. Mo

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.