

S. No. 2
 DM-2-43
 v. 5-17-39
 X35697

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

12587

FILED MAY 3 1945

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1821

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:
3828 Chestnut
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 43 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 946 Ohio
(If rural, give location)
 (e) Citizen of foreign country? No 2 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Alida S. Swanson

3. (b) If veteran, name war X No
 3. (c) Social Security No. None

4. Sex Female 5. Color or race Wh.
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Oscar Swanson
 6. (c) Age of husband or wife if alive 70 yrs. years
 7. Birth date of deceased Nov. 29, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 4 24 hr. min.

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

10. Usual occupation Housewife

11. Industry or business At Home

12. Name John Broberg

13. Birthplace X Sweden
(State or foreign country)

14. Maiden name Christine

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

16. (a) Informant Mrs. Alice Linnerson
 (b) Address 3828 Chestnut K.C.Mo.

17. (a) Burial (b) Date thereof 4/25/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park K.C.Ks.
Also Porter & Sons

18. (a) Signature of funeral director Edmondson
 (b) Address 915 N. 10th K.C.Ks.

19. (a) 4-23-45 (b) Seraldine Holmes
(Date received local Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
 year 1945 hour 4 minutes 55 A.M.

21. I hereby certify that I attended the deceased from Nov 15
1944 to April 22 1945
 that I last saw her Et alive on April 22 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death, Deabzhi Coma
 Due to Deabzhi Mellitus

Due Also to Sentic
 Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
 Of operations None
 Of autopsy No

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
 (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

23. Signature Edmondson (M. D. or other)
 Address 4-23-45 Date signed _____

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

STATEMENT BY LICENSED EMBALMER

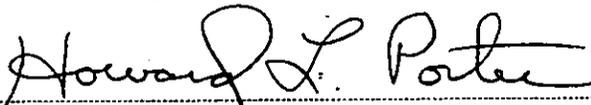
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Howard L. Porter.....

Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. **3751**.....

P. O. Address **915 N. 10th K.C.Ks.**.....

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.