V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 25 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29521

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3758

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~~: ST. LUKE'S HOSPITAL O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 2-DAYS (Specify whether

In this community 42-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. 1408 WEST-42ND STREET (If rural, give location)

(e) Citizen of foreign country? YES (Yes or No)

If yes, name country SWEDEN

3. (a) PRINT FULL NAME MR. CARL August ANDERSON

3. (b) If veteran, name war no

3. (c) Social Security No. 510-07-8507

4. Sex MALE C

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of ~~husband or~~ wife MRS. SIGNE ANDERSON

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased DECEMBER (Month) 11 (Day) 1884 (Year)

8. AGE: Years 60 Months 8 Days 28 If less than one day ___ hr. ___ min.

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

10. Usual occupation GROCERY CLERK

11. Industry or business FRANK FORSBERG GROCERY K.C.KAS

FATHER
12. Name AUGUST ANDERSON
13. Birthplace (City, town, or county) SWEDEN 4 (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace (City, town, or county) SWEDEN 11 (State or foreign country)

16. (a) Informant MRS. SIGNE ANDERSON

(b) Address 1408 WEST-42ND STREET

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT-11-1945 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ FOREST HILL CEMETERY

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 9-11-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 9TH year 1945 hour 6 minute 00 P.M.

21. I hereby certify that I attended the deceased from Sept. 7, 1945, to Sept. 9, 1945, that I last saw him alive on Sept. 9, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other conditions none (Include pregnancy within 3 months of death)

Major findings: Of operations 83a

Of autopsy no

Duration 2½ dys. (?)

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 B. Atchison (M. D. ~~or other~~)

Address 522 Professional Date signed Sept 10 1945

86 (Licensed Embalmer's Statement on Reverse Side)

522 Professional Bldg
10-4

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 Oscar Storkey

Licensed Embalmer No. 1767

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.