

S. No. 2  
M-543  
7. 5-17-39  
I X36671

FILED DEC 29 1948 / 49

State File No. \_\_\_\_\_  
Registrar's No. 5027

Registration District No. \_\_\_\_\_ 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: 4145 Wyoming  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX  
(Specify whether)

In this community 68 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 4145 Wyoming  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. EMMA S. RYDEN

3. (b) If veteran, name war XX

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9th  
year 1948 hour 6:00 minute A. M.

4. Sex Fe / 5. Color or race Wh

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

6. (b) Name of husband or wife August Ryden

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

7. Birth date of deceased November 14 1852  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1937  
19\_\_\_\_ to 8 Dec 1948  
that I last saw h. et alive on 8 Dec 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
96 0 25 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Generalized Arterio Sclerosis Ant. Scler. Heart disease

Duration ?

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

10. Usual occupation At Home

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

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

MOTHER FATHER { 12. Name Peter Peterson

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

14. Maiden name No Record

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Rev. Ernest E. Ryden

(b) Address Moline, Illinois

17. (a) Burial (b) Date thereof 12-11-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 12-9-48 (b) R. Thaldine Holme  
(Data received local registrar) (Registrar's signature)

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? \_\_\_\_\_

Robert M. Myers (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Robert M. Myers (M. D. or other) M.D.  
Address Rialto Bldg. Date signed \_\_\_\_\_

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

11-475-1  
Kwatts

**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 Alvin R. Hainscheld

Licensed Embalmer No. 4159

P. O. Address Kansas City 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.