

No. 300
10. 48

FILED JUL 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25764

97
2

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 143

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Marshall b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall	
c. LENGTH OF STAY (In this place) 2 weeks			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Fitzgibbons hospital		d. STREET ADDRESS (If rural, give location) 1347 South Conway	

3. NAME OF DECEASED (Type or Print) a. (First) Henry	b. (Middle) -----	c. (Last) Erickson	4. DATE OF DEATH (Month) (Day) (Year) July 13, 1949
--	-------------------	---------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never married	8. DATE OF BIRTH Dec. 28, 1882	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Hours 15	Min. -----
--------------------	-------------------------------	--	---------------------------------------	---	---------------------------------	----------------------------------	------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement finisher	10b. KIND OF BUSINESS OR INDUSTRY Concrete work	11. BIRTHPLACE (State or foreign country) Kansas City, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Andrew Gustav Erickson	13b. MOTHER'S MAIDEN NAME Matilda Carlson	14. NAME OF HUSBAND OR WIFE -----
--	--	-----------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 487-24-8191	17. INFORMANT'S SIGNATURE OR NAME John Erickson	ADDRESS 8607 Wilson Rd. K.C. Mo.
---	--	--	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac. Meningitis		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Auto accident		2 1/2 hrs
	DUE TO (c) -----		8 1/2 hrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Concussion			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION -----	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) -----	21b. PLACE OF INJURY (e.g., in or about home, store, factory, street, office bldg., etc.) Street	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Marshall Saline Mo
--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 29, 1949 5:30	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Unknown - Cool. No. 197
--	--	--

22. I hereby certify that I attended the deceased from **June 29, 1949** to **July 3, 1949**, that I last saw the deceased alive on **July 3, 1949**, and that death occurred at **2:5 p.m.** from the causes and on the date stated above.

23a. SIGNATURE Robert M. Lewis M.D. (Degree or title)	23b. ADDRESS Marshall Mo	23c. DATE SIGNED 7-14-49
--	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 15, 1949	24c. NAME OF CEMETERY OR CREMATORY Ridge Park cemetery	24d. LOCATION (City, town, or county) (State) Marshall, Mo.
---	--------------------------------	---	---

DATE REC'D BY LOCAL REG. July 15-1949	REGISTRAR'S SIGNATURE Sidney J Gray 385	25. FUNERAL DIRECTOR'S SIGNATURE Campbell-Lewis Marshall Mo	ADDRESS By W. Campbell
--	--	--	-------------------------------

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED JUL 18
District Health Officer No. 8,

District File Number _____

Date Filed 7-19-47

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed R. W. Campbell Jr.

Signed _____
Student Embalmer

Licensed Embalmer No. 3469

P. O. Address Marshall 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.