

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40680****5146**BIRTH NO. 21-154-50 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5146

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|--|-------------------------------|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Caldwell</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u> | | c. LENGTH OF STAY (in this place) <u>3 hrs.</u> | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hamilton</u> | | d. STREET ADDRESS (If rural, give location) <u>X</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CONLEY MATERNITY HOSPITAL</u> | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Jerry</u> b. (Middle) <u>WAYNE</u> c. (Last) <u>EKLUND</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 5, 1950</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u> | 8. DATE OF BIRTH <u>Dec. 4, 1950</u> | | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u> IF UNDER 24 HRS. Hours <u>7</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Robert Eklund</u> | | 13b. MOTHER'S MAIDEN NAME <u>Uivian Siem</u> | | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Robert Eklund</u> | | ADDRESS <u>Hamilton, Mo.</u> | | | | |
| 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. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atelectasis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u> <u>31 hrs</u> <u>76 hrs</u> | |
| 19a. DATE OF OPERATION | | 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, farm, factory, street, office bldg., etc.) | | |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 21f. HOW DID INJURY OCCUR? | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>12-4</u> , 19 <u>50</u> , to <u>12-5</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>12-5</u> , 19 <u>50</u> , and that death occurred at <u>2:40 p.m.</u> , from the causes and on the date stated above. | | | | | | |
| 23a. SIGNATURE <u>Margaret Jones</u> (Degree or title) | | | 23b. ADDRESS <u>R. D. 23-6 39th K. C. Mo.</u> | | 23c. DATE SIGNED <u>12-6-50</u> | |
| 24a. BURIAL, CREMATION REMOVAL (Specify) <u>Cremated</u> | | 24b. DATE <u>4-2-50</u> | 24c. NAME OF CEMETERY OR CREMATORY | | 24d. LOCATION (City, town, or county) (State) <u>Hamilton, Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>12-6-50</u> | | REGISTRAR'S SIGNATURE <u>Thereldine Holmes</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Stine + Mc. Clure</u> ADDRESS <u>K. C. Mo.</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.