

FILED AUG 1 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21793

State File No.

BIRTH NO.		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>633</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Greene</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (If in this place) <u>1 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Verona</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Rt. # 1</u>			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>Theodore</u>	b. (Middle) <u>H.</u>	c. (Last) <u>Erickson</u>	(Month) <u>July</u>	(Day) <u>23</u>	(Year) <u>1955</u>	Male	6. COLOR OR RACE <u>White</u>
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 12, 1888</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Lawrence County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Fred Erickson</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Buren</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel V. Erickson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John H. Erickson, Collegeboro, Georgia.</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>DISSECTING ANEURISM OF ASCENDING AORTA</u>				<u>48 Hours</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) <u>AORTIC ANEURISM DUE TO UNDETERMINED CAUSE.</u>					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death.				<u>-451X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>July 23, 1955</u> , to <u>July 23, 1955</u> , that I last saw the deceased alive on <u>July 23, 1955</u> , and that death occurred at <u>4:37 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Glenn O. Thomas M.D.</u>				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>7/25/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/26/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Springriver Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Verona, Missouri.</u>		
DATE REC'D BY LOCAL REG. <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>Lois Williamson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul L. Mars</u>		ADDRESS <u>Aurora, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WHITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 10 1910

Lawrence	Missouri	Greene
	Verona	Springfield
	H. W. I	St. John Hospital
July 23, 1922	Erickson	H.
	April 12, 1888	White
U.S.A.	Lawrence County	Farming
	Mabel V. Erickson	Emma Buran
	John H. Erickson, College, Georgia	None

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.

Student
Student Embalmer

Signed Robert E. Mulleman

Licensed Embalmer No. 4915

P. O. Address Springfield

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.

August, Mo.