

No. 300  
10.48

FILED JAN 31 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2098

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 236 PRIMARY REG. DIST. NO. 5819 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Clay</u>		
b. CITY OR TOWN <u>Rural Osage Township</u>		c. LENGTH OF STAY (in this place) <u>1 week</u>	c. CITY OR TOWN <u>Clay Center</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>18 M. S. Versailles, Mo.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>G.</u> c. (Last) <u>Fahlstrom</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 21, 1956</u>		

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 4, 1884</u>		9. AGE (In years last birthday) <u>71</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> IF UNDER 2 HRS. Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Clay Center Kansas</u>	
13a. FATHER'S NAME <u>Jacob Fahlstrom</u>			13b. MOTHER'S MAIDEN NAME <u>No Record</u>		14. NAME OF HUSBAND OR WIFE <u>Ludie G. Fahlstrom</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>459-05-8196</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ludie G. Fahlstrom Clay Center, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Parkinsons Disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>with Myocardial Insufficiency</u> DUE TO (c) <u>Acute Coronary</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Thrombosis with</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>45 min</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Pulmonary Oedema</u>			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) <u>4201</u>		
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 1950, 19  , to 1956, 19  , that I last saw the deceased alive on 1-21, 1956 and that death occurred at 9:35 PM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John H. Ogilvie M.D.</u>	23b. ADDRESS <u>224 Realto Bldg K.C. Mo</u>		23c. DATE SIGNED <u>1-23-56</u>
---	--	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>23 Jan. 56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Forrest Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
---	--------------------------------	--	---	--

DATE REC'D BY LOCAL REG. <u>1/23/56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>214-0</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. F. Kibull Versailles, Mo.</u>	
--	--	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

APR 17 1956

---

---

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.....  
Signature of Student Embalmer

Signed.....  
*Raymond C. Foster*

Licensed Embalmer No. *H. 6. 2. 6*

P. O. Address *Wesley*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.