

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1290

STATE FILE NUMBER

FILED FEB 4 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 177

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <i>Kansas City Mo</i> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Kansas City</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>8001 Garboe</i>		Length of stay in <i>25 yrs</i>	
		d. STREET ADDRESS <i>8001 Garboe</i> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>Mr John Gustafson</i>			4. DATE OF DEATH <i>1-12-1957</i>			
First Middle Last			Month Day Year			

5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-28-1902</i>	9. AGE (In years last birthday) <i>54</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabinet maker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Display Studios</i>	11. BIRTHPLACE (City and state or country) <i>Sweden</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Gustaf Gustafson</i>	14. MOTHER'S MAIDEN NAME <i>Paulina unknown</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>496-10-7689</i>	17. INFORMANT Address <i>Herdis Gustafson, 8001 Garboe</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crownway Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>arteriosclerotic heart disease</i>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Geo C Kealhofer M.D. Deputy coroner</i>	22b. ADDRESS <i>3300 S. 1st St. St. Louis 8 Mo</i>	22c. DATE SIGNED <i>1-13-57</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-15-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Forest Hill</i>	23d. LOCATION (City, town, or county) (State) <i>Kansas City Mo</i>
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24. FUNERAL DIRECTOR ADDRESS <i>Francis Wornall Funeral Home K.C. Mo</i>	25. DATE RECD. BY LOCAL REG. <i>1-14-57</i>	26. REGISTRAR'S SIGNATURE <i>Irene Minshall</i>
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(Licensed Embalmer's Statement on Reverse Side)

alth, Welfare Public Service
300-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms written on this form. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Geo. C. Kealhofer

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 *Russell N. Fran*.....

Licensed Embalmer No. *42*
P. O. Address *K.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.