

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 18 1957

44327  
STATE FILE NUMBER  
5694

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 5694

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <del>Missouri</del> <b>Kansas</b> b. COUNTY <del>Johnson</del> <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Kansas City</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Overland Park</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		Length of stay in 1b <b>6 Days</b>	d. STREET ADDRESS (If outside, give location) <b>8415 Robinson</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ALBIN</b> Last <b>ECKLUND</b>		4. DATE OF DEATH Month <b>11</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 13 1896</b>
9. AGE (In years at birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>13</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>K. C. Terminal R. R.</b>	11. BIRTHPLACE (City and state or country) <b>St. Mary's Kansas</b>
		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13a. FATHER'S NAME <b>Gus Ecklund</b>		13b. MOTHER'S MAIDEN NAME <b>Rose Larsen</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Betty Ecklund</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give month, dates of service) <b>Yes W. W. # 1</b>		16. SOCIAL SECURITY NO. <b>703 03 8929</b>	17. INFORMANT Address <b>Ka.</b> <b>Mrs. Betty Ecklund 8415 Robinson Overland Pk</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>2224</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b> <b>3 weeks.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute Ruptured Gastric Ulcer (5 days)</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)	
20c. TIME OF INJURY Hour <b>11:30</b> Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
21. I attended the deceased from <b>Nov. 24, 1957</b> to <b>Nov. 29, 1957</b> and last saw her alive on <b>Nov. 29, 1957</b> - Death occurred at <b>11:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John K. Caldwell MD</b>		22b. ADDRESS <b>306 E 12 ST. Kansas City, Mo.</b>	22c. DATE SIGNED <b>12/2/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-3-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City 33 Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Floral Hills Mem. Chapels, Inc K.C.Mo</b>		25. DATE RECD. BY LOCAL REG. <b>12-2-57</b>	26. REGISTRAR'S SIGNATURE <b>Neval Trinsball</b>

MEDICAL CERTIFICATION  
John K. Caldwell USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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No. 1-1454 - 1st x M<sup>o</sup> Me



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 *W. J. Prossinger*  
Licensed Embalmer No. *3938*  
P. O. Address *N. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.