

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029004  
STATE FILE NUMBER 3987

FILED SEP 5 1958

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2947 Baltimore		d. STREET ADDRESS (If outside, give location) 2947 Baltimore	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA ALSTROM		4. DATE OF DEATH Month Day Year August 19 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 25 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Philipstad, Sweden
13a. FATHER'S NAME John Johanson		13b. MOTHER'S MAIDEN NAME Anna Unknown	14. NAME OF HUSBAND OR WIFE Charles J Alstrom
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs Ruth Boles - 1616 E. 67th St Kc Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH 491 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hemiparesis (arteriosclerotic) of Right Foot			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
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
21. I attended the deceased from 12/18/57 to 8/19/58 and last saw her alive on 7-28-58 Death occurred at 4:50 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE M. H. Hesser (Degree or title) M.P.		22b. ADDRESS Kansas City, Kansas	22c. DATE SIGNED 8/19/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE August 20 1958	23c. NAME OF CEMETERY OR CREMATORY Snt Marial Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Mo
24. FUNERAL DIRECTOR Milko Funeral Home 2315 Lenwood		25. DATE RECD. BY LOCKE REG. 8-19-58	26. REGISTRAR'S SIGNATURE neva minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

H. H. Hesser

300

All diseases in Part I must be causally related.

72

Dr. Nease  
New-Bristol Road 1904  
2 - 5:30 P.M.

### 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 *Chas E. Wilks* .....

Licensed Embalmer No. *2644* .....

P. O. Address *19 E. 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.