. Health,
& Welfare
. Public
h Service

S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-029320
STATE FILE NUMBER

FILED SEP 5 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4006

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3506 Roberts — Length of stay in 1b 18 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 3506 Roberts (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Carl Middle: Ivor Last: Wistrom.
4. DATE OF DEATH Month: Aug Day: 17 Year: 1958
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan 15 1879
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Clerk
10b. KIND OF BUSINESS OR INDUSTRY Hotel
11. BIRTHPLACE (City and state or country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Klaus Wistrom
13b. MOTHER'S MAIDEN NAME Amelia Peterson
14. NAME OF HUSBAND OR WIFE Hazel Wistrom
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 521-18-8979
17. INFORMANT Hazel Wistrom, Address 3506 Roberts K.C. Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Stomach & general — 5 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) metastasis
DUE TO (c) 151X

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? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 3-13-51 to 8-17-58 and last saw him alive on 8-4-58
Death occurred at 10:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Fred H. Lundgren Jr MD (Degree or title)
22b. ADDRESS 227 Plaza Medical Bldg.
22c. DATE SIGNED 8-18-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE August 20-1958
23c. NAME OF CEMETERY OR CREMATORY Memorial Park
23d. LOCATION (City, town, or county) Kansas City (State) Missouri

24. FUNERAL DIRECTOR Mrs. C.L. Forster Funeral Home, Inc. ADDRESS Kansas City Missouri.
25. DATE RECD. BY LOCAL REG. 8-19-58
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Fred H. Lundgren, Jr.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Tried N [illegible]
any time after 1/2/30 P

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 John R. Sidmo

Licensed Embalmer No. 4531

P. O. Address Kansas City

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.