

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005910  
STATE FILE NUMBER 892

FILED MAR 9 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</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>Linwood N. Home</b>		Length of stay in lb <b>25 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>418 E. 9th St.</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALBERTA</b> Middle <b>F.</b> Last <b>STROMGREN</b>			4. DATE OF DEATH Month <b>2</b> Day <b>14</b> Year <b>59</b>		
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-1873</b>	9. AGE (In years and month) <b>85 05</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>Artist</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Waterloo, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Charles Stromgren</b>		13b. MOTHER'S MAIDEN NAME <b>Laura Anderson</b>		14. NAME OF HUSBAND OR WIFE <b>XX</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <b>XX</b>		16. SOCIAL SECURITY NO. <b>486-05-3764</b>	17. INFORMANT Address <b>John Stromgren, Arlington, California</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>arteriosclerosis</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs</b> <b>9 yrs</b>
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 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 <b>11:30 A.M. 1-1-59</b> to <b>2:14:59</b> and last saw her/him alive on <b>2-14-59</b> . 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) <b>Frank Paul Lawrence MD</b>			22b. ADDRESS <b>428 S. White Ave</b>		22c. DATE SIGNED <b>2-14-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-17-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>Wagner Funeral Home. K C Mo</b>			25. DATE RECD. BY LOCAL REG. <b>2-16-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Frank Paul Lawrence MD

All diseases in Part I must be causally related.

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 *Alvin R. Haunschild*

Licensed Embalmer No. *4159*  
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.