

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 25 1960

=60-001935

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 124 STATE FILE NUMBER

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		Length of stay in lb 60 Yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 113 East 69th Ter.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 113 East 69th Terrace			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FRANK Middle A. Last SWENSON				4. DATE OF DEATH Month Jan. Day 7, Year 1960			
5. SEX Male	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 9-19-1868	9. AGE (last birthday) 91	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Cabinet Maker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Sweden		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Sven Larsson			13b. MOTHER'S MAIDEN NAME Mathilda Carlson			14. NAME OF HUSBAND OR WIFE Hulda A. Swenson	
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 Address Mrs. Julius Johnson Kansas City, 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) Acute Pulmonary Edema						INTERVAL BETWEEN ONSET AND DEATH 4 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Acute Coronary Thrombosis						2 days	
DUE TO (c) Generalized Arteriosclerosis						10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a))						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 p.m.							
20d. INJURY OCCURRED WHILE AT WORK <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 Jan-10-1955 to Jan-7-60 and last saw him alive on Jan-7-60 Death (occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) Carl H. Brust M.D.				22b. ADDRESS 106 W 14th St K.C. Mo		22c. DATE SIGNED Jan-8-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-9-1960	23c. NAME OF CEMETERY OR CREMATORY Forest Hill		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.		
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. Jan. 8, 1960		26. REGISTRAR'S SIGNATURE Neva Marshall	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Carl H. Brust

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. H. Green

Licensed Embalmer No. 29

P. O. Address F. O.

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