DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Washington State Department of Health

VITAL STATISTICS
CERTIFICATE OF DEATH

State File No. 337
Registrar's No. 357

1. PLACE OF DEATH:
(a) County Snohomish
(b) City or town Everett (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Providence Hospital (If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution 2 days. In this community (Specify whether Years, months or days) 16 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington (b) County Snohomish
(c) City or town Everett (If outside city or town limits, write RURAL)
(d) Street No. 2508 Grand. (If rural give location)
(e) If foreign born, how long in U. S. A.? 42 years

3. (a) FULL NAME John Erickson
3. (b) Was decedent ever a member of the Army, Navy or Marine Corps of the United States? / Name of organization in which such service was rendered / Rank / Period of service
3. (c) Social Security Number 533-09-0859

4. Sex: Male
5. Color or race: White
6(a) Single, widowed, married, divorced: Married.
6. (b) Name of husband or wife: Hannah
6(c) Age of husband or wife if alive 62 years
7. Birth date of deceased: July (Month) 29 (Day) 1886 (Year)
8. AGE: Years 59 | Months 1 | Days 16 | If less than one day ___ hr. ___ min.
9. Birthplace Finland (City, town or county) (State or foreign country)
10. Usual occupation Laborer 9-45-01
11. Industry or business Robinson Mfg. Co.
Father 12. Name Eric Jacobson
13. Birthplace Finland (City, town, or county) (State or foreign country)
Mother 14. Maiden name Sofia Marie
15. Birthplace Finland (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Carl A. Johnson
(b) Address 2813-21 to St E. Everett Wn.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18-45 (Month) (Day) (Year)
(c) Place: burial or cremation Everett Wash.
18. (a) Signature of funeral director Bullecomb & Fickel
(b) Address 2719 Oak Everett Wash
19. (a) 9/18/45 (Date received local registrar) (b) B. Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month Sept. day 15th
year 1945 hour 7 minute 9
21. I hereby certify that I attended the deceased from Sept. 13, 1945, to Sept. 15, 1945; that I last saw him alive on Sept. 15, 1945; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Internal hemorrhage into bowel with obstruction of (1 day)
Due to bowels, mesenteric thrombosis 3 days
Due to 99
Other conditions (Include pregnancy within 3 months of death) Chr. Constipation - Varicose veins of both ankles for
Major findings:
Of operations None
Of autopsy Autopsy not granted.

Physician — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work (e) Means of injury (M. D. or other)
23. Signature [illegible] M.D.
Address 318 Medical Dental Bldg. Date signed 9-17-45