

E15729

No. 2  
-11-2-39  
5-17-39  
I X21492DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 4877  
1707  
Registrar's No.Registration District No. 791Primary Registration District No. 1003

## 1. PLACE OF DEATH:

- (a) County St. Louis, Missouri / 0  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Hospital, #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 Days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

8. (a) PRENT FULL NAME Ben Olson

3. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
About 68 hr. min.9. Birthplace Sweden 7  
(City, town, or county) (State or foreign country)10. Usual occupation Nil 7

11. Industry or business \_\_\_\_\_

- MOTHER FATHER  
12. Name Ed Olsen 7  
13. Birthplace Sweden 7  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Sweden 7  
(City, town, or county) (State or foreign country)

16. (a) Informant Brig. K. Larson  
(b) Address 1427 Locust ( Salvation Army17. (a) Burial (b) Date thereof 2/20/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cemetery18. (a) Signature of funeral director Edith E. Ambruster  
(b) Address 4234 Manchester19. (a) FEB 19 1940 (b) J. P. Black

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 25  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1427 Locust  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17,  
year 1940 hour 6:30 minute \_\_\_\_\_ P. M.21. I hereby certify that I attended the deceased from February  
11, 19 40 to February 17, 19 40  
that I last saw him alive on February 17, 19 40  
and that death occurred on the date and hour stated above.Immediate cause of death \_\_\_\_\_ Duration  
Cerebral Hemorrhage 6 days

Due to \_\_\_\_\_ year

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_ PHYSICIAN  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature Walter Ford (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette, Date Signed 2/19/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....

.....  
working under my personal supervision.

....., Registered Apprentice No.....

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**