

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9879

State File No.

Registrar's No. 1313

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
815 West 39th Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 55 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME ANNIE OLSON 425

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Bear Olson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 19, 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 5 If less than one day hr. _____ min.

9. Birthplace Sweden
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Swanson

13. Birthplace Sweden
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. G. Curbertson
(b) Address 815 W. 39

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-26-40
(Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cem.

18. (a) Signature of funeral director Jurk & Taber Co.
(b) Address Kansas City, Mo.

19. (a) Mar 25, 1940 (Date received local registrar) (b) M. M. Browe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 815 West 39th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar 3 day 3 of 1940 year 1940 hour 2:00 minute PM M.

21. I hereby certify that I attended the deceased from 1-12-40 to 3-24-40 that I last saw him alive on 3-24-40 and that death occurred on 3-24-40 date and hour stated above.

Immediate cause of death Myocardial Infarction

Due to Chronic Hypertension

Due to 930

Other conditions Chronic myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy no

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) Manner of injury: _____

23. Signature J. St. Bonje (M. D. or other)
Address Paris, Mo. Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Dr. T. S. Bourke
Argyle Bldg.

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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.....

....., Registered Apprentice No:.....
working under my personal supervision.

Signed..... *Charles M. Quick*

Licensed Embalmer No. *3774*

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.