

NOV 12 1940

Primary Registration District No. 1002

Registrar's No.

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: K.C. General Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution From 8-27-40 to 10-12-40
(Specify whether
 In this community 6 Months.
years, months or days)

3. (a) PRINT FULL NAME CARL OLSON

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Alice Olson 6. (c) Age of husband or wife if alive deceased
 7. Birth date of deceased 2-18-1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>8</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Forest Ranger

11. Industry or business Govt. Serv.

12. Name Olie N. Olson

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

14. Maiden name Ella Knutsen

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

16. (a) Informant Mrs. Love

(b) Address 807 Kensington

17. (a) Burial (b) Date thereof 10-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Home Cem

18. (a) Signature of funeral director John P. Shul

(b) Address 6606 Independence

19. (a) 10-23-40 (b) M. M. Brown
(Date received local registrar) (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 limit write "RURAL")
 (d) Street No. 2434 Indiana
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20th
 year 1940 hour 2 minute 0 P.M.

21. I hereby certify that I attended the deceased from Aug. 27th, 1940, to Oct. 20th, 1940;

that I last saw him alive on Oct. 12th, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death _____

CARCINOMA OF PROSTATE

Due to _____

Due to 51

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy See above

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) (Specify means of injury)

23. Signature Wiley R. Shaw (M. D. or other) 10-21-1940
 Address Med. Dir. J. C. Gen. Hosp. Date signed _____

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1940
62
78

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.....

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.