

FILED FEB 24 1942  
Registration District No. 791

Primary Registration District No. 1003

State File No. \_\_\_\_\_  
Registrar's No. 1040

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Johns Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 Weeks.  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4628a Olive Street.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Katherine Olsen.  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month December day 28th.  
year 1941 hour 10 minute 45 P.M.

4. Sex F. / 5. Color or race W. M.  
6. (a) Single, widowed, married, divorced Widowed.  
6. (b) Name of husband or wife Fred Olsen.  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 1, 1865  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from October 23<sup>rd</sup> 1941 to Dec 28<sup>th</sup> 1941.  
that I last saw her alive on Dec 28<sup>th</sup> 1941  
and that death occurred on the date and hour stated above

8. AGE: Years Months Days If less than one day  
76 5 27 hr. min.

Immediate cause of death acute cardiac failure Duration 2 1/2 days  
Due to Cancer of uterus - ?  
Cancer of urinary bladder - ?  
Due to primary site the uterus  
generalized carcinoma  
Other conditions hypertension, cystitis  
(Include pregnancy within 6 months of death)

9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation At Home.

PHYSICIAN  
Major findings:  
Of operations none  
Of autopsy none  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name William Martin.  
13. Birthplace Scotland.  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Maher.  
15. Birthplace Ireland.  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Otto W. Hackwolf.  
(b) Address 4261 Laclede Ave.  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-41  
(Month) (Day) (Year)  
(c) Place: burial or cremation S.S. Peter & Paul Cemetery

(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature George J. McKee (M. D. or other) \_\_\_\_\_  
Address 2903 Olive Date signed 2/29/42

18. (a) Signature of funeral director Arthur J. Donnelly  
(b) Address 2840 2nd St Bldg  
19. (a) 30 1941 (Date received local registrar) (b) J. F. Brudick (Registrar's signature)

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

00  
17  
99

1-1-1  
3903  
W. Van Matre

**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 W. Van Matre  
Licensed Embalmer No. 2825  
P. O. Address 4340 Lafayette

**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, fact should be so stated above.**