V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32840

FILED OCT 23 1945

Registration District No. 199 Primary Registration District No. 1002 Registrar's No. 4174

48
3
8

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~~: MENORAH HOSPITAL O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 3 WEEKS (Specify whether
In this community 11 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3817 EAST 36TH STREET 8
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country --

3. (a) PRINT FULL NAME MR. VANCE EARL OLSON, SR.

3. (b) If veteran, name war WORLD WAR I

3. (c) Social Security No. 499-10-9827

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of ~~husband or~~ wife MRS. LILLIAN OLSON

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased SEPTEMBER (Month) 17 (Day) 1897 (Year)

8. AGE: Years 48 Months 0 Days 20 If less than one day ___ hr. ___ min.

9. Birthplace FOREST CITY (City, town, or county) IOWA (State or foreign country)

10. Usual occupation TELEGRAPHER

11. Industry or business R.C. TERMINAL RAILWAY CO.

FATHER
12. Name JOHN OLSON
13. Birthplace (City, town, or county) IOWA (State or foreign country)

MOTHER
14. Maiden name MAUDE COLE
15. Birthplace FOREST CITY (City, town, or county) IOWA (State or foreign country)

16. (a) Informant MRS. LILLIAN OLSON

(b) Address 3817 EAST 36TH STREET

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct. 10, 1945 (Month) (Day) (Year)

(c) Place: ~~burial or~~ cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 10-10-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 7TH year 1945 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9/11/45, 19__, to 10/7/45, 19__; that I last saw him alive on 10/7/45, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Malignant Hypertension 3 mo.

Due to

Due to

Other conditions 95c
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Cerebral edema Cardiac hypertrophy

Duration

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

23. Signature Harold Fairman M. D. or other

Address Prof Bldg Date signed 10/8

(Licensed Embalmer's Statement on Reverse Side)

Professional Reg
1116

NOV 2 1945

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 Emile M. Colbourn

Licensed Embalmer No. 3506

P. O. Address K C Mo

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.