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U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 15 1947

STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 28453
Registrar's No. 84

Registration District No. 243 Primary Registration District No. 2047

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

1. PLACE OF DEATH:
 (a) County NEWTON
 (b) City or town NEOSHO
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) 5 Years

3. (a) PRINT FULL NAME Leslie L. Olson
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 56 Months _____ Days _____
 If less than one day hr. _____ min. _____

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

10. Usual occupation Insurance Salesman

11. Industry or business Metropolitan Insurance

MOTHER FATHER
 12. Name William Olson
 13. Birthplace Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name Betty Brennen
 15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. S. Gunning
 (b) Address Webb City Mo.

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof Aug. 28, 47
(Month) (Day) (Year)

(c) Place: burial or cremation Carl Junction Cem.

18. (a) Signature of funeral director Johnston-Arnice-Simpson
 (b) Address Webb City, Mo. Mortuary

19. (a) Sept. 3, 1947 (b) Melvin C. Bowman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County NEWTON 73
 (c) City or town NEOSHO 3
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location) 2
 (e) Citizen of foreign country? _____ (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: about Aug. 24
 Month _____ day 24
 year 1947 hour 12 minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on Aug. 27, 1947,
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cause of death unknown
Natural Causes
 Due to Probable coronary thrombosis
 Due to Had been dead several days
when found
 Other conditions _____
(include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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?

While at work _____ (Specify type of place)
 Means of injury 5
 23. Signature Corley Thompson
(M.D. or other)
 Address Neosho Mo. Date signed 8/27/47

SEP 26 1947

District Health Officer No. 947-183
I.D. File Number 9-10-47

RECEIVED

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.....

Jack C. Simpson, Registered Apprentice No. *38*
working under my personal supervision.

Signed: *Clayton M. Johnston*

Licensed Embalmer No. *4304*

P. O. Address *Webb City, 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.