

Registration District No. 149

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 St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hour
(Specify whether years, months or days) 1 hour

3: (a) PRINT FULL NAME Baby Giel Olson

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

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

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

7. Birth date of deceased 7 18 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 1 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Howard Albin Olson

13. Birthplace Mission Hill, S. D.
(City, town, or county) (State or foreign country)

14. Maiden name W. Signa Janice Calmus

15. Birthplace La Crosse, Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. A. Olson

(b) Address 5801 Stone Blvd. K.C. Kans

17. (a) Cremation (b) Date thereof 7 19 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Lukes Hospital

18. (a) Signature of funeral director St. Lukes Hospital

(b) Address 44th & Miss. Creek Plenary

19. (a) 7-24-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Lyon
(c) City or town Kansas City 944
(If outside city or town limits, write "RURAL")
(d) Street No. 5801 Stone Blvd. 140
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18th
year 1948 hour 9 minute 00 A. M.

21. I hereby certify that I attended the deceased from 8:00 A.M.
7-18, 1948, to 9:00 A.M. 7-18, 1948
that I last saw h. or alive on 7-18, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Overdose of
Medic
(non-malignant)

Due to _____
Due to _____
Other conditions 157A
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Aspirin

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) Means of injury _____
23. Signature J. G. H. [unclear] (M. D. or other) _____
Address St. Lukes Hospital Date signed _____

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

MOTHER FATHER

78
3
8

5-5-e

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, fact should be so stated above.