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FILED NOV 30 1948 3

Registration District No. _____

Primary Registration District No. **5430**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Franklin**

(b) City or town **Rural Robertsville, Mo.**
(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 _____
In this community **50 yrs** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **ELIZABETH OLSON**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **widow**

6. (b) Name of husband or wife **Deceased**

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

7. Birth date of deceased **July 24, 1877**
(Month) (Day) (Year)

8. AGE: Years **71** Months **3** Days **18**
If less than one day _____ hr. _____ min.

9. Birthplace **Jefferson Co. Mo. U**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Own Home**

12. Name **Fredrick Hagemann**

13. Birthplace **West Halla Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Henrietta Claus**

15. Birthplace **Hanover Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Fred Olson**

(b) Address **St. Clair, Mo.**

17. (a) **Rural** (b) Date thereof **11/14/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dittmer, Mo.**

18. (a) Signature of funeral director **Casey & Tenax**

(b) Address **St. Clair, Mo.**

19. (a) **11-13-48** (b) **Paul E. Miller**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Franklin**

(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **Robertsville, Mo. P.R.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **12** th
year **1948** hour **7** minute **14** - M.

21. I hereby certify that I attended the deceased from **11-8-48**
_____ 19**48** to **11-12-48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Central Nervous System**

Duration _____

Due to _____

Due to **Renal Arteriosclerosis**

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

Major findings: Of operations **g30**

Of autopsy _____

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? _____

23. Signature **W. E. Tuttle** (M. D. or other) _____
Address **St. Clair Mo** Date signed **11/13**

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed NOV 29 1948

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 David C. Russell

Licensed Embalmer No. 4520

P. O. Address St. Clair, 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.