

FILED SEP 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

H. Olson
State File No. 27443

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 328

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give RURAL and give township) OR TOWN <u>Brookfield</u>		c. LENGTH OF STAY (in this place) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>924 Strawbridge</u>		c. CITY (If outside corporate limits, give RURAL and give township) OR TOWN <u>Brookfield</u> 1582	
d. STREET ADDRESS (If rural, give location) <u>924 Strawbridge</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Pleasant</u> b. (Middle) <u>Lee</u> c. (Last) <u>Crouse</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug-31-1950</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept-18-1871</u>
9. AGE (In years last birthday) <u>78</u> MONTHS <u>11</u> DAYS <u>13</u>		10. USUAL OCCUPATION (Give kind of work not counting most of working life, even if retired) <u>Retired Drug Dealer</u>	
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State for foreign country) <u>Kolo Missouri</u>	
12. CITY/TEN/OF WHAT COUNTRY <u>Mo</u>		13a. FATHER'S NAME <u>Matthew Crouse</u>	
13b. MOTHER'S MAIDEN NAME <u>D.K.</u>		13c. NAME OF HUSBAND OR WIFE <u>Sarah Crouse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Orville Burns</u>		ADDRESS <u>Brookfield Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis general</u> DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pneumonia terminal</u> <u>3 31X</u> <u>2 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>8-23, 1950</u> , to <u>8-31, 1950</u> , that I last saw the deceased alive on <u>8-30, 1950</u> , and that death occurred at <u>12:30 am.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>H. T. Olson</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Brookfield Mo</u>	
23c. DATE SIGNED <u>8-31-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		24b. DATE <u>Sept-1-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Zimmerman</u>		24d. LOCATION (City, town, or county) (State) <u>Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-1-50</u>		REGISTRAR'S SIGNATURE <u>H. B. Erwin</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>167 Hill</u>		ADDRESS <u>Funeral Home Brookfield Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

5582

Date Received: SEP 5 1950
DISTRICT HEALTH OFFICE #2
District File Number 9-50-14
Date Filed: SEP 7 1950

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *J. B. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address *Brookfield 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.