

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18435
5012

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)	
John		F.		OLSON	
4. DATE OF DEATH		(Month)		(Day) (Year)	
5		5		1951	
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
Male		White		WIDOWER	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	
11/18/99		52		UNK	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
MISSOURI		0			
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
UNK		UNK		UNK	
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	
UNK		UNK		O L Taylor 1300 Clark	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	
		Coronary Sclerosis			
		ANTECEDENT CAUSES			
		Chronic Myocarditis			
		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
				4201	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:55 A.M., from the causes and on the date stated above.

23a. SIGNATURE		23b. ADDRESS		23c. DATE SIGNED	
[Signature]		1300 Clark		5/24/51	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
		6 MAY 31 1951		Annuity Board	
24d. LOCATION (City, town, or county) (State)		24e. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		Rowland Mortuary Service Inc.			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		52. FUNERAL DIRECTOR'S SIGNATURE	
MAY 24 1951		[Signature]		Rowland Mortuary Service Inc.	

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

81

X

42
FILED JUN 15 1951

DEC 11 1951

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.....

Students of Mortuary College Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed *James G. Lemmers*

Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

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.