

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25040

State File No. 62336
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 62336			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) 11 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS				d. STREET ADDRESS (If rural, give location) 4103a South Grand Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hospital				15				215-9/0	
3. NAME OF DECEASED (Type or Print) a. (First) EDWARD			b. (Middle) C.		c. (Last) OLSON		4. DATE OF DEATH (Month) (Day) (Year) July 8, 1954		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Feb. 19, 1887		9. AGE (In years last birthday) 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railway Conductor			10b. KIND OF BUSINESS OR INDUSTRY Railway		11. BIRTHPLACE (State or foreign country) Rushford, Minn.		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Frederick Olson			13b. MOTHER'S MAIDEN NAME Bertha Johnson			14. NAME OF HUSBAND OR WIFE Gertrude Hanlon Olson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Gertrude Olson, 4103a So. Grand Ave.				ADDRESS _____	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma						INTERVAL BETWEEN ONSET AND DEATH 1 year	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) of Rt. lower Lung							
		DUE TO (c) _____							
		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 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? 163X					
22. I hereby certify that I attended the deceased from June 10, 1954 , to July 8, 1954 , that I last saw the deceased alive on July 7, 1954 and that death occurred at 12:52A m., from the causes and on the date stated above.									
23a. SIGNATURE [Signature] (Degree or title) MD				23b. ADDRESS 3606 St. Louis		23c. DATE SIGNED 7/9/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE July 12, 1954		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		24d. LOCATION (City, town, or county) St. Louis County, Missouri		(State) _____	
DATE REC'D BY LOCAL REG. JUL 10 1954		REGISTRAR'S SIGNATURE [Signature]			25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Beidervieden F.H.Inc., 1936 St. Louis Ave.				

(Licensed Embalmer's Statement on Reverse Side)

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

Mr. H.
Dr. Weinsberg
S.S. Natl Bank Bldg.
Hrs. - 2-4
PR 3-2959

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 _____

Licensed Embalmer No. 4520

P. O. Address. *H. S. ...*

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.