

37120

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

No. 300
10-48

FILED DEC 10 1956

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1275

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>Life</u>		e. STREET ADDRESS (If rural, give location) <u>RFD # 4</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Edmond</u>	b. (Middle) <u>C.</u>	c. (Last) <u>Olson Sr.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 28, 1956</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 14, 1895</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dist. Foreman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. State Hwy. Dept.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Buchanan Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Edward P. Olson</u>	13b. MOTHER'S MAIDEN NAME <u>Hilma Erickson</u>	14. NAME OF HUSBAND OR WIFE <u>Mamie Olson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>495-26-2300</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mamie Olson</u>	ADDRESS <u>R. 4 St. Joseph, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Guillain-Barre Syndrome</u> <u>Idiopathic polyneuritis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 11-18, 1956, to 11-28, 1956, that I last saw the deceased alive on 11-27, 1956, and that death occurred at 1:30a m., from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) <u>Robert A. Kiehl, MD</u>	23b. ADDRESS <u>St. Joseph, Mo.</u>	23c. DATE SIGNED <u>11-28-56</u>
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24a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11-30-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Dec. 3, 1956</u>	REGISTRAR'S SIGNATURE <u>Lothar M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman W. Sidenfaden</u>	ADDRESS <u>St. Joseph, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr Kieber
Kirkpatrick Bldg

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.....
Signature of Student Embalmer

Signed.....
Robert H. Gable
Licensed Embalmer No. 3308

P. O. Address St. Joseph.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.