

Health,
& Welfare
Public
Service

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
B. I. Burns

FILED NOV 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36045

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5003

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen'l Hosp. #1</u>		Length of stay in lb <u>5 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>519 W. 11</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bo</u> Middle <u>Olofson</u> Last <u>Olofson</u>			4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1918</u>	9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brettons Rest.</u>	11. BIRTHPLACE (City and state or country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
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>486-36-7430</u>	17. INFORMANT Address <u>Gen Hosp #1</u> <u>Record Clerk</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia probably tuberculous</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<u>002+</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Oct. 21, 1957</u> to <u>Oct. 21, 1957</u> and last saw <u>him</u> alive on <u>Oct. 21, 1957</u> Death occurred at <u>9:58 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>B. I. Burns, M.D.</u> (Degree or title)			22b. ADDRESS <u>24th & Cherry</u>		22c. DATE SIGNED <u>10-22-57</u>
23a. BURIAL CREMATION <u>burial</u>		23b. DATE <u>10-26-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Elmwood R.C.Mo</u>		23d. LOCATION (City, town, or county) (State) <u>R.C.Mo</u>
24. FUNERAL DIRECTOR <u>B.E. Weasel R.C. Mo</u> Address _____			25. DATE RECD. BY LOCAL REG. <u>10-28-57</u>		26. REGISTRAR'S SIGNATURE <u>neva Minshall</u>

(Licensed Embalmer's Statement on Reverse Side)



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 *BE Weiss*.....

Licensed Embalmer No. *4075*
P. O. Address *RC 8 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.