

t. Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-027029

STATE FILE NUMBER

2 5829

FILED VS JUL 24 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4724 Minnesota Ave.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>4724 Minnesota Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Olsen</b> Last			4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1907</b>
9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Joseph H. Weavers</b>	
13b. MOTHER'S MAIDEN NAME <b>Katherine Schleutker</b>		14. NAME OF HUSBAND OR WIFE <b>Julius B. Olsen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Joseph J. Wevers - 3935 Blaine Ave.</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic pulmonary edema superimposed on severe suppurative pulmonary disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>527.1</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <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 _____ and last saw <sup>her</sup> him alive on _____ Death occurred at <b>345 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Paul J. Simon</b> (Degree or title) <b>3</b>		22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>6/19/59</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 22, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Concordia Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis City, Missouri</b>
24. FUNERAL DIRECTOR <b>WACKER-HELDERLE-3634 Gravois Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 19 59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith. M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 Delbert J. Krupin  
Licensed Embalmer No. 3497  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.