

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038433**

FILED **V8 NOV 2 1959**

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2780

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Pagedale</b>		c. CITY OR TOWN <b>Pagedale</b>	
Length of stay in 1b <b>59 years</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>6718 Schofield Avenue</b>		d. STREET ADDRESS (If outside, give location) <b>6718 Schofield Avenue</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>OLSEN</b> Last			4. DATE OF DEATH Month <b>October</b> Day <b>19</b> Year <b>1959</b>		
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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>11/27/75</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Ortkras</b>	13b. MOTHER'S MAIDEN NAME <b>Angela Lindemann</b>	14. NAME OF HUSBAND OR WIFE <b>Louis Olsen</b>
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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) <b>no none</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Alma Olsen, 6718 Schofield Avenue</b>	Address
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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>arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
DUE TO (b) <b>arteriosclerosis</b>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour <b>11:10</b> a.m. p.m.	Month, Day, Year <b>10-19-59</b>
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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 <b>St. Louis</b> COUNTY <b>St. Louis</b> STATE <b>Missouri</b>
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21. I attended the deceased from **Jan - 59** to **Oct. 19 - 59** and last saw her/him alive on **10-17-59**  
Death occurred at **11:10 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>J. D. [Signature]</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>608 Kingsland</b>	22c. DATE SIGNED <b>10-20-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct 22, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR <b>Shepard Funeral Home, 1167 Hamilton Avenue</b>	25. DATE RECD. BY LOCAL REG. <b>10-21-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elmo R. Sadu

Licensed Embalmer No. 4077

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.