21 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5756

1. PLACE OF DEATH.
County Newton — Registration District No. 611 — File No.
Township — Primary Registration District No. 5812 — Registered No.
City Seneca RD 2 (No. ... St. ... Ward)

2. FULL NAME Theodore Orrick Olson
(a) Residence. No. ... St., ... Ward. ... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 10 1918

7. AGE: Years 9 — Months 3 — Days 6 — If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Seneca RD

PARENTS
10. NAME OF FATHER Therodore Olson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Seneca Mo
12. MAIDEN NAME OF MOTHER Dora Sparlin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Seneca

14. INFORMANT T. Olson
(Address) Seneca RD 2

15. FILED 2/18, 1928 C. E. Norris REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/16 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1928, to Feb 16, 1928 that I last saw him alive on Feb 16, 1928, and that death occurred, on the date stated above, at 2:10 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
appendicitis
121
(duration) yrs. mos. ds

CONTRIBUTORY (SECONDARY) 1 1/13
(duration) yrs. mos. ds

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) P. G. Hunnley, M. D.
Feb 18, 1928 (Address) Seneca Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Gallamore Cemetery — DATE OF BURIAL: Feb 18 1928

20. UNDERTAKER: Norman E. Mitchell — ADDRESS: Seneca

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.

Township..... Primary Registration District No..... Register

City..... (No....., ...

2. FULL NAME .....

(a) Residence: No..... St., ... Ward. .....
(Usual place of abode) (If nonresident

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATI

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I
....., 19....., to .....
that I last saw h..... alive on.....
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLL

.....
.....
.....
.....(duratio

CONTRIBUTORY.....
(SECONDARY)
.....(duratio

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or
(1) MEANS AND NATURE OF INJURY, and (2
HOMICIDAL. (See reverse side for additional space

19. PLACE OF BURIAL, CREMATION, OR F

20. UNDERTAKER