

LED JUN 17 1940

Registration District No. 399Primary Registration District No. 1002Registrar's No. 2203

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Trinity Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution one yr
 (Specify whether years, months or days) 32 mo

3. (a) PRINT FULL NAME

Ola P. Logan 250

8. (b) If veteran, name war

Ola P. Logan8. (c) Social Security No. 4. Sex female5. Color or race white6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife

Lorine Logan6. (c) Age of husband or wife if alive years

7. Birth date of deceased

Unknown1848

8. AGE:

Years

Months

Days

If less than one day

92 hr. min.

9. Birthplace

Sweden

(City, town, or county) (State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

9

12. Name

Unknown9

13. Birthplace

Unknown

(City, town, or county) (State or foreign country)

14. Maiden name

Unknown

15. Birthplace

Unknown

(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Rev. A. H. Lindquist

(b) Address

2914 E 1317. (a) removal
(Burial, cremation, or removal)

(b) Date thereof

5-29-40

(c) Place: burial or cremation

Denver Colo

18. (a) Signature of funeral director

A. P. Doehler

(b) Address

1415 East 1519. (a) May 29, 1940
(Date received local registrar)(b) M. M. Crow
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2914 E 30
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 73 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May, day 26
 year 1940 hour 11:40 minute 19 M.

21. I hereby certify that I attended the deceased from May 19-1940
 to May 26, 1940

that I last saw him alive on May 26, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary atherosclerosis

Duration

1 day

Due to

Chronic myocarditis

Due to

arteriosclerosis + senility

Due to

92

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
361 (Specify type of place)

While at work? _____ (e) Means of injury fall

23. Signature Carl H. Lindquist M.D. (M. D. or other)

Address 704 E. 13th Date signed _____

0060

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *H. P. Doehler*

Licensed Embalmer No. 1166

P. O. Address 1415 East 15

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 this body is not embalmed, above space should be left blank.