

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**

28477  
Do not use this space.

SEP 13 1940

1. PLACE OF DEATH

(a) County Gentry Registration District No. 20 309

(b) Township \_\_\_\_\_ Primary Registration District No. 4185 Registered No. 23

(c) City Albany (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Martin Olson 425

(a) Residence, No. Albany mo St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 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) Jan. 9 1877

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
	<u>63</u>	<u>6</u>	<u>29</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farm hand

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden 7

FATHER

13. NAME Urdorm

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT Dan Jameson  
(ADDRESS) Mc. Fall, Mo. R. F. D.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Zion DATE Aug. 8, 1940

19. FUNERAL DIRECTOR Brooks Funeral Home  
(ADDRESS) Albany, Mo

20. FILED Aug. 16, 1940 W. T. Martin Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-8-1940

22. I HEREBY CERTIFY, That I attended deceased from 8-8-1940, to 8-8-1940, 1940.  
I last saw him alive on died before I saw him, 19    . Death is said to have occurred on the date stated above, at 9 a.m.  
The principal cause of death and related causes of importance were as follows:

Gored + Crushed in chest by bull.  
(3 holes gored in chest and most of ribs in front crushed in)

Other contributory causes of importance: \_\_\_\_\_

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? inspection Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? yes Date of injury 8-8-1940  
Where did injury occur? farm - Mc Fall, Mo.  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. farm

Manner of injury gored by bull  
Nature of injury gored + crushed chest

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) Frank H. Rose M. D.  
(Address) Albany, Mo.

RECEIVED  
District Health Officer No. 11,  
District File Number *840-1368*  
Date Filed *SEP 11 1940*

STATEMENT BY LICENSED EMBALMER

I, Clifford Brooks, Licensed Embalmer No. 3329

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed

*Clifford Brooks*

Licensed Embalmer No. 3329

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.)