

Registration District No. 678.

Primary Registration District No. 59-04 4404

Registrar's No.

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Phelps.

(a) County \_\_\_\_\_  
 (b) City or town St James,  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 25 Years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Elizabeth Olson.

3. (b) If veteran, X name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex. Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If alive \_\_\_\_\_ years  
 7. Birth date of deceased. October, 16th, 1857  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>2</u>	<u>13</u>	_____ hr. _____ min.

9. Birthplace Sweden.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business Not known.

MOTHER FATHER { 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name II  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs James Malloy

(b) Address St James Mo

17. (a) Burial (b) Date thereof 1-7-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wagoner Cemetery

18. (a) Signature of funeral director St James Mo

(b) Address \_\_\_\_\_

19. (a) 1-7-41 (b) Elizabeth Olson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Phelps,  
 (c) City or town St James,  
(If outside city or town limits, write "RURAL")  
 (d) Street No. X  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 40 years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month December, 30th day  
 year 1940. hour 7 minute 38 M.

21. I hereby certify that I attended the deceased from Dec 26  
1940 to Dec 30, 1940  
 that I last saw or alive on Dec 29, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Pneumonia  
 Duration 12/24/40

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions IIII  
(Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature William H. Miller (M. D. or other) \_\_\_\_\_

Address St James Mo Date signed 12/31/40

52 1441

RECEIVED  
District Health Officer No. 5,  
District File Number 147/140  
Date Filed

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.