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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2229

248
8
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of Hospital or institution: 5745 Cherry Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 73 years (Specify whether years, months or days)

In this community 73 years

2. USUAL RESIDENCE OF DECEASED: 048
mca

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 5745 Cherry Street 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 73 years years.

3. (a) PRINT FULL NAME Mrs. Margaret Olson

3. (b) If veteran, No name war. 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Matthias Olson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 26, 1853
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>6</u>	<u>13</u>	hr. _____ min. _____

9. Birthplace Sweden 4
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

12. Name Nels Dahl

13. Birthplace Sweden 4
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Sweden 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Algot Jackson

(b) Address 5745 Cherry Street

17. (a) Mt. Moriah (b) Date thereof 6-11-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Freeman Mortuary

18. (a) Signature of funeral director _____
(b) Address Kansas City, Missouri

19. (a) 6/10/1941 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9th
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from MAY 19
19 4 to June 9 19 4
that I last saw her alive on June 9 19 4
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Senility

Due to Mental Impairment

Other conditions 92B
(Include pregnancy within 3 months of death)

Major findings: 9219
Of operations _____

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury Car

23. Signature Margaret Olson (M. D. or other) MD
Address 1103 E. 9th Date signed 6/10/41

1103 East Ansonia
New Milford 30108

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 Clarence H. Chiles

Licensed Embalmer No. 3473

P. O. Address 76 E 760

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, fact should be so stated above.