

FILED JUL 13 1943
Registration District No. **749**

Primary Registration District No. **1002**

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

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 General Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days
 In this community unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2412 Kensington
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Anton Olsen

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

4. Sex Male **5. Color or Race** White

6. (a) Name of husband or wife Pearl Olsen **6. (b) Age of husband or wife if alive** _____ years

7. Birth date of deceased May 16 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>1</u>	<u>12</u>	hr. _____ min.

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

10. Usual occupation Med. Dir. on Hospital

11. Industry or business Self

MOTHER, FATHER

12. Name Ben Olsen
13. Birthplace Sweden (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Sweden (City, town, or county) (State or foreign country)

16. (a) Informant Pearl Olsen

(b) Address 2412 Kensington

17. (a) Burial, cremation, or removal Removed **(b) Date thereof** 6-28-43
(Month) (Day) (Year)

(c) Place: burial or cremation Clay Center Hall

18. (a) Signature of funeral director H. C. Mo

(b) Address H. C. Mo

19. (a) Date received local registrar 6-28-43 **(b) Registrar's signature** J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1943 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from June 23 1943 to June 28 1943
that I last saw him alive on June 28 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia following cataract operation

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy None

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 _____

23. Signature Wm. R. Johnson (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed 6-28-43

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 *W. B. Blackman*

Licensed Embalmer No. 2244

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, fact should be so stated above.

Registration District No. 149

Primary Registration District No. 1002

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

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Anton Olsen
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... May 16 (Month) (Day) (Year)

8. AGE: Years 74 Months Days If less than one day, min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June year 1943 hour 8 minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....
that I saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death Myocardial infarction following Colostomy operation 108 Duration

Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy.....

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..... (M. D. or other)
Address..... Date signed.....

SUPPLEMENTARY

20540