

FILED OCT 23 1946  
Registration District No. 128

Primary Registration District No. 2000

State File No. \_\_\_\_\_  
Registrar's No. 797

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
842 North Robberson  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community Since 1888  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 842 North Robberson  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN OLSON

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Olga Olson (dec)

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 24, 1868  
(Month) (Day) (Year)

8. AGE: <input checked="" type="checkbox"/> Years	Months	Days	If less than one day
<u>78</u>	<u>0</u>	<u>8</u>	hr. _____ min. <u>4</u>

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

10. Usual occupation Ret'd Postal Carrier and Clerk

11. Industry or business U.S. Government

MOTHER FATHER { 12. Name Ola Johnson

13. Birthplace Sweden

14. Maiden name Christine Henderson

15. Birthplace Sweden

16. (a) Informant Freda Olson (sister)

(b) Address 842 N. Robberson

17. (a) Burial (b) Date thereof 10/4/1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HAZELWOOD CEMETERY

18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL HOME

(b) Address SPRINGFIELD, MISSOURI

19. (a) 10-3-46 (b) W. E. Handley MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2nd  
year 1946 hour 6:00A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
unattended, 19 by Physician, 19 \_\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death probably chronic myocarditis

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 93D

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 \_\_\_\_\_

23. Signature W. E. Handley Registrar  
Address Springfield Mo (M. D. or other) \_\_\_\_\_  
Date signed 10-4-46

APR 10 1967

NOV 17 1967

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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.....

*L. A. Roof*

Licensed Embalmer No.....

*3044*

P. O. Address.....

*Springfield, MS*

**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. .

*X*