

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **ST. LOUIS**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **FIRMIN DESLOGE HOSPITAL**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 DAY**  
(Specify whether years, months or days) **40 YEARS**

3. (a) PRINT FULL NAME **EDWARD OLSON**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W**  
6. (a) Single, widowed, divorced, or married **(married)**  
6. (b) Name of husband or wife **BLANCHE OLSON**  
6. (c) Age of husband or wife if alive **61** years  
7. Birth date of deceased **SEPT-11-1880**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **6** Days **2**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **RETIRED GENERAL HAULER**

11. Industry or business \_\_\_\_\_

12. Name **OLAF INGUARSON**  
13. Birthplace **SWEDEN**  
14. Maiden name **BENGETA ANDERSON**  
15. Birthplace **SWEDEN**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Joseph Olson**  
(b) Address **3928 Council Grove**  
17. (a) **Burial** (b) Date thereof **3-17-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **CALVARY CEMETERY**

18. (a) Signature of funeral director **L. B. Turner**  
(b) Address **6107 Natural Bridge**  
19. (a) **MAR 16 1948** (b) **J. F. Bredeler**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**  
(c) City or town **PINE LAWN**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3928 COUNCIL GROVE**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **13**  
year **1948** hour **11** minute **45 P.M.**  
21. I hereby certify that I attended the deceased from **February 20**, 1948, to **March 17**, 1948  
that I last saw him alive on **March 13**, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Embolus**  
Duration **5 hours**

Due to **Phlebotrombosis, femoral vein**

Due to **Hemiplegia, right, following cerebral vascular thrombosis**  
Other conditions **Arterial Hypertension**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_

23. Signature **Clement J. Sullivan** (M. D. or other) **MD**  
Address **607 N. Grand St. Louisville** Date signed **3-15-48**

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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 *John S. Kennedy*  
Licensed Embalmer No. *4199*  
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.**