

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21509**  
Registrar's No. **5267**

BIRTH NO. **38044-49** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <b>MO</b>		b. COUNTY <b>021</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS</b>		c. LENGTH OF STAY (In this place) <b>20 HRS.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>DEPAUL HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>1533<sup>c</sup> MARCUS</b> <b>DEPAUL HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) <b>INFANT</b>			a. (First)			b. (Middle)			c. (Last) <b>OLSON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 17, 1949</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>CHILD</b>		8. DATE OF BIRTH <b>JUNE 16, 1949</b>			9. AGE (In years last birthday)		10. MONTHS		11. DAYS		12. IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>				11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS, MO</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				

13a. FATHER'S NAME <b>JOHN OLSON</b>			13b. MOTHER'S MAIDEN NAME <b>AUDREY ARMING</b>			14. NAME OF HUSBAND OR WIFE <b>NONE</b>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>JOHN OLSON</b>		ADDRESS <b>1533<sup>c</sup> MARCUS</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Fatal atelectasis</b>		DUE TO (b) <b>Pulmonary hypoplasia</b>					
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>Premature separation of placenta</b>					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>absent</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>161<sup>a</sup></b>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <b>7620</b>	
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22. I hereby certify that I attended the deceased from **6-16**, 19**49**, to **6-17**, 19**49**, that I last saw the deceased alive on **6/17**, 19**49**, and that death occurred at **9 AM** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>C. H. Hamilton, M.D.</b>		23b. ADDRESS <b>4500 Olive St</b>		23c. DATE SIGNED <b>6/17/49</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JUNE 18, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS CO., MO</b>	
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DATE REC'D BY LOCAL REG. <b>JUN 17 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Pasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wedmeyer &amp; Sons</b>		ADDRESS <b>3934 N. 209<sup>t</sup></b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

Student Embalmer No. \_\_\_\_\_

working under my personal supervision

Signed \_\_\_\_\_

*Needle P. Lohwetter*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *3696*

P. O. Address. *3934 N 20th St*

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.