

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 26174

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>947</u>		
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>59 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		d. STREET ADDRESS (If rural, give location) <u>2619 So 15th</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hosp. # 2</u>				d. STREET ADDRESS (If rural, give location) <u>2619 So 15th</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ida</u> b. (Middle) <u>Rendena</u> c. (Last) <u>Olsen</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 27, 1949</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed 21</u>		8. DATE OF BIRTH <u>Aug. 6, 1866</u>		
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>-</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>-</u> Mins. <u>-</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Christiansand, Norway</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>unknown</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Charston Olsen</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Marie Miller St. Joseph, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) * This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>lobar pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile deterioration</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>490X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>June 27, 1949</u> , to <u>8-27</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-27</u> , 1949, and that death occurred at <u>10³⁰ P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Deputy or title) <u>C. Hopkins M.D.</u>				23b. ADDRESS <u>State Hospital # 2</u>		23c. DATE SIGNED <u>8-27-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>8/30/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Sept 6, 1949</u>		REGISTRAR'S SIGNATURE <u>C. L. Jenkins 382</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Heaton Bowman Funeral St. Joseph, Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

Home

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

MAR 17 1950

SEP 12 1949

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.....
Student Embalmer

Signed..... *William Spackling*

Licensed Embalmer No. *4535*

P. O. Address *319 S. 10th, S. D. 57012*

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.