

No. 300
0.48
160

FILED JAN 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43675**

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5550 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY OR TOWN <u>Caulfield</u> <small>(If outside corporate limits, write RURAL and give township)</small>	c. LENGTH OF STAY (In this place) <u>65 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Caulfield</u> <u>0437</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS <u>R.H.D.</u> <small>(If rural, give location)</small>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Norman</u> b. (Middle) <u>M.</u> c. (Last) <u>Olsen</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12-20-49</u>
---	---

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W-2</u>	8. DATE OF BIRTH <u>9-27-1866</u>	9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-----------------	---------------------------	---	-----------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Hambler Co. Tenn</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	---	---	---

13a. FATHER'S NAME <u>Geo. P. Olsen</u>	13b. MOTHER'S MAIDEN NAME <u>Bytha Mayes</u>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME - ADDRESS <u>A.R. Olson, Caulfield 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute dilatation of heart</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Chronic nephritis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		592X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 6-16-49 to 12-20-1949, that I last saw the deceased alive on 12-16-1949, and that death occurred at 11:45 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Daniel R. Brown, M.D.</u>	23b. ADDRESS <u>Baptist Hospital - Mo</u>	23c. DATE SIGNED <u>1-8-50</u>
---	---	--------------------------------

24a. BURIAL, CREMATION, REINTERMENT (Specify)	24b. DATE <u>12-20-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lowler</u>	24d. LOCATION (City, town, or county) (State) <u>Howell Mo</u>
---	---------------------------	--	--

DATE REC'D BY LOCAL REG. <u>1-18-50</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	EMERALD DIRECTOR'S SIGNATURE <u>Robertson</u>	ADDRESS <u>St Paul, Mo</u>
---	--	---	----------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 1/23/50
District Health Officer No. 5,
District File Number... 15065
Date Filed 1/26/50

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.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.

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.