

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33653**

FILED NOV 4 1950

4394

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City mo</u>		c. LENGTH OF STAY (in this place) <u>3 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City mo</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Gen Hospital # 1</u>				d. STREET ADDRESS (If rural, give location) <u>1324 E 12 st</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Melvin E</u> b. (Middle) <u>Olsson</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 15 50</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>		8. DATE OF BIRTH <u>Sept 3 - 1947</u>	
9. AGE (In years last birthday) <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Kansas City mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Frank Olsson</u>		13b. MOTHER'S MAIDEN NAME <u>Sola B Olsson</u>		14. NAME OF HUSBAND OR WIFE <u>Child</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>Sola B Olsson 1324 E 12</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Bacterial Meningitis</u> ANTECEDENT CAUSES <u>Occurred as a complication of</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Etiology</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS: <u>6570</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Autopsy at Gen Hosp # 2</u>				20. AUTOPSY? YES <input checked="" 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) _____		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Type or Print) <u>Thos. A. Jones</u>				23b. ADDRESS _____		23c. DATE SIGNED <u>10/17/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Oct 20, 50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Founders Park</u>		24d. LOCATION (City, town, or county) (State) <u>Founders Park</u>	
DATE REC'D BY LOCAL REG. <u>10-17-50</u>		REGISTRAR'S SIGNATURE <u>M. H. Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Shakers Bros 2304 Pine</u>			

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

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 _____

B. L. Seaman

Signed.....
Student Embalmer

Licensed Embalmer No. _____

2540

P. O. Address _____

2304

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.