

FILED NOV 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40960

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10513

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		a. STATE Missouri	b. COUNTY Crawford
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cuba	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) Rural Route #3	

3. NAME OF DECEASED (Type or Print)	a. (First) Albert	b. (Middle)	c. (Last) Olsen	4. DATE OF DEATH (Month) (Day) (Year) 11/4/53
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct., 11, 1890	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	10b. KIND OF BUSINESS OR INDUSTRY Printing	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME Julius Olsen	13b. MOTHER'S MAIDEN NAME Caroline Christensen	14. NAME OF HUSBAND OR WIFE May Olsen
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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) NO	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS May Olsen, Cuba Missouri
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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) PULMONARY EMBOLUS		4 MINUTES
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) THROMBOPHLEBITIS DUE TO (c) CARCINOMA OF LUNG		4 DAYS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4 MONTHS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 163X
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22. I hereby certify that I attended the deceased from 10-28, 1953, to 11-4, 1953, that I last saw the deceased alive on 11-4, 1953, and that death occurred at 8:55a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M.D. 0	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 11-4-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11-4-53	24c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	24d. LOCATION (City, town, or county) (State) St. James Missouri
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DATE RECD BY LOCAL REGISTRAR'S SIGNATURE NOV 5 1953	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington
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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..

Student.....
Signature of Student Embalmer

Signed..... *Paul A. Wackler*

Licensed Embalmer No. *4787*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.