

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016953

STATE FILE NUMBER

FILED MAY 14 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1205

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis City</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>Koch, Mo</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rob. Koch Hosp.</b> Length of stay in 1b <b>5yrs 5mos 28d</b>		STREET ADDRESS (If outside, give location) <b>8220 N. Broadway</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Leslie</b> Middle <b>Bernard</b> Last <b>Olson</b>			4. DATE OF DEATH Month <b>5</b> Day <b>2</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-30-09</b>	
9. AGE (In years last birthday) <b>48</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Labor Pool</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo</b>
13. FATHER'S NAME <b>Andy Olson</b>		14. MOTHER'S MAIDEN NAME <b>Albertina Stone</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>499-124,398</b>		17. INFORMANT <b>Records, Koch Hosp. Koch, Mo</b> Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) <b>Hypogonadism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from <b>11-25-52</b> to <b>5-2-58</b> and last saw <sup>DEK</sup> him alive on <b>5-2-58</b> Death occurred at <b>12:15</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>H.A. Harris MD</b> (Degree or title)		22b. ADDRESS <b>Koch Hospital, Koch, Mo.</b>	22c. DATE SIGNED <b>5-2-58</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>5/5/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Bethlehem Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>			25. DATE RECD. BY LOCAL REG. <b>5-5-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert P. Danke M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service  
 300-56  
 Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 Use only black ink or ribbon typewrite if possible.

REGISTRATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Stanley H. Dixon*  
Licensed Embalmer No. *419*

P. O. Address *St. L.*

MAY 15 1958

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.