

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006252

STATE FILE NUMBER

FILED MAR 10 1959

Registration District No. 175 Primary Registration District No. 303b Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>LAWRENCE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAWRENCE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>AURORA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>AURORA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CRESTVIEW HOME</u>		Length of stay in 1b <u>3 weeks.</u>	d. STREET ADDRESS (If outside, give location) <u>107 East Meade</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WOLA</u> Middle <u>MAY</u> Last <u>OLSEN</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-3-1884</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>28</u> IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME MAKING</u>	11. BIRTHPLACE (City and state or country) <u>MORRISON, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>EDWARD RAE</u>		13b. MOTHER'S MAIDEN NAME <u>EMILINE PITTMAN</u>		14. NAME OF HUSBAND OR WIFE <u>CRIS OLSEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <u>NO</u> unknown) (If yes, give dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT Address <u>CRIS OLSEN, AURORA, MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Vascular accident</u> DUE TO (c) <u>Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>12 hrs.</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> <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 <u>-</u> Month, Day, Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>					
20d. INJURY OCCURRED WHILE AT <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 <u>Feb. 25 1959</u> to <u>March 1 1959</u> and last saw her/him alive on <u>March 1 1959</u> Death occurred at <u>6:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Harold E. George D.</u>			22b. ADDRESS <u>W. Morrow Mo.</u>		22c. DATE SIGNED <u>3/3/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-4-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple park cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Aurora Mo.</u>
24. FUNERAL DIRECTOR <u>Walter L. Marsh</u> ADDRESS <u>Aurora Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>3-3-1959</u>		26. REGISTRAR'S SIGNATURE <u>Oran Mc Natt</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Myself....., Student Embalmer No. 4213..... working under my personal supervision.

Student
Signature of Student Embalmer

Signed Gordon P. Bennett.....

Licensed Embalmer No. 4213.....
P. O. Address W. Bennett.....

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.