

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022974

STATE FILE NUMBER

FILED JUL 2 1959

Registration District No. _____ Primary Registration District No. _____

Registration No. **5776**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS C.I.Y. HOSP. #1.		d. STREET ADDRESS (If outside, give location) 3825 Delmar	

3. NAME OF DECEASED (Type or print) First OLGA Middle HEAROLD Last			4. DATE OF DEATH Month JUNE Day 15 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1920	9. AGE (In years last birthday) 39	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress	10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (City and state or country) Mt. Horeb, Wisconsin	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Even Odegaard	13b. MOTHER'S MAIDEN NAME Olive Haugland	14. NAME OF HUSBAND OR WIFE Unknown
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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. _____	17. INFORMANT Address Thea Bonner, Mt. Horeb, Wisconsin
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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>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Lung abscess</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	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
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21. I attended the deceased from <u>6/13/59</u> to <u>6/15/59</u> and last saw her alive on <u>6/15/59</u> Death occurred at <u>1:05 A.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>James Young M.D.</u>	22b. ADDRESS <u>1515 LAFAYETTE AVE</u>	22c. DATE SIGNED <u>6/15/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-17-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. JUN 17 '59	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 *Melvin L Kemper*

Licensed Embalmer No. *4052*

P. O. Address *4911 Wash St*

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.