

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-036903

FILED VS/ OCT 1 0 1960

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 2872 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland		Length of stay in 1b 15 yrs	c. CITY OR TOWN Overland Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1935 N Warson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1935 N Warson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Arthur Middle B Last Olson			4. DATE OF DEATH Month Sept Day 30 Year 1960		
5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/16/1894	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (City and state or country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME William Olson		13b. MOTHER'S MAIDEN NAME Laola Baldwin		14. NAME OF HUSBAND OR WIFE Susie Rusch Olson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW # 1	16. SOCIAL SECURITY NO. 494-01-4475	17. INFORMANT Susie Olson Overland Mo
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

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 _____ s.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 1956 to Sept 30 1960 and last saw her/him alive on Sept 29 1960
Death occurred at 6:45 7 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J.C. Redington M.D.	22b. ADDRESS 950 Frances Pl Clayton 5 Mo	22c. DATE SIGNED 9-30-60
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/3/60	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery	23d. LOCATION (City, town, or county) (State) St Louis Mo
--	-----------------------------	--	---

24. FUNERAL DIRECTOR Ortmann F Home	ADDRESS 9222 Lackland Overland Mo	25. DATE RECD. BY LOCAL REG. 9-30-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
---	---	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

9-30-60

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed W. C. D. [Signature]

Licensed Embalmer No. 3478

P. O. Address _____

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