

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027281

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3567

1. PLACE OF DEATH a. COUNTY JACKSON b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in 1b 60 YEARS c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3320 TROOST AVENUE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 3320 TROOST AVENUE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUCY ISABEL OLSEN		4. DATE OF DEATH JULY 5th 1962	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 4/11/81	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY SINGER SEWING	
11. BIRTHPLACE (City and state or country) BUNKER HILL ILLINOIS U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Fogarty		13b. MOTHER'S MAIDEN NAME Margaret Milligan	
14. NAME OF HUSBAND OR WIFE DR. OLE C. OLSEN		Address 3320 TROOST AVE. KANSAS CITY, MO.	
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. None	
17. INFORMANT DR. OLE C. OLSEN		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Atherosclerosis, Cerebral & Generalized DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malnutrition 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 INTERVAL BETWEEN ONSET AND DEATH Subd.	
19. WAS AUTOPSY PERFORMED? YES <input 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.)	
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 _____ to _____ and last saw her alive on July 5, 1962 Death occurred at July 5, 1962 5.00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) Otho M. Theel M.D.		22b. ADDRESS 4301 Main St. HCMo 76-62	
22c. DATE SIGNED 7-7-62		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 7-7-62		23c. NAME OF CEMETERY OR PLACE OF BURIAL MT MORIAH CEMETERY	
23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI		24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS	
24. ADDRESS 1331 Brush Creek Blvd. KANSAS CITY MO		25. DATE RECD. BY LOCAL REG. 7-7-62	
26. REGISTRAR'S SIGNATURE Ruth N Long			

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **O.W. Theel**

USE BLACK INK OR TYPEWRITER RIBBON

19. Otto W. Thiel Sr.
Room 5 - 2nd Floor
4301 Main Street
100 - 5101

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 Thomas W. Thielson

Licensed Embalmer No. 4889
P. O. Address Lutheop, Mo.

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.