MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27342

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No. 3603
City Kansas City (No. 3124 Wayne St. Ward)

2. FULL NAME Edith S Hanson
(a) Residence. No. 3124 Wayne St., 13 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hans N Hanson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 11th 1859

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ___ hrs. or ___ min.
68	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

PARENTS
10. NAME OF FATHER Swanson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden

14. INFORMANT Tom C Hanson
(Address) 3635 Jefferson

15. FILED 9/20, 1927 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep 18th 1927

17. I HEREBY CERTIFY, That I attended deceased from 9/18/27, 19__, to 9/18/27, 19__, that I last saw her alive on 1 P.M., 19__, and that death occurred, on the date stated above, at 11:30 P.M. m.

82A THE CAUSE OF DEATH* WAS AS FOLLOWS: Central Hemorrhage
97
102 74A1
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hypertension (Antiquity Schools)
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Usual
(Signed) H P Farber, M. D
9/19, 1927 (Address) 1325 Malto Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Forest Hill
DATE OF BURIAL: 9-20-1927

20. UNDERTAKER: H. C. Bergman
ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible] WITH UNFADING INK—THIS IS A PERMANENT RECORD

per Kuhn.
1325 [illegible] Bldg.