

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

Township.....

Primary Registration District No. 1001

City St. Joseph

(No. St. Joseph's Hospital.)

18656
File No.
Registered No. 583
St. Ward)

2. FULL NAME James Iver Hansen.

(a) Residence. No. 1420 Sycamore Street. St. Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married.

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

Clara Mathilda Hansen.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 4, 1891.

7. AGE

YEARS
39

MONTHS
5

DAYS
6

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sign Writer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer Himself.

9. BIRTHPLACE (CITY OR TOWN) St. Joseph,
(STATE OR COUNTRY) Missouri.

10. NAME OF FATHER John M. Hansen.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown.
(STATE OR COUNTRY) Norway.

12. MAIDEN NAME OF MOTHER Minnie Thompson.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown.
(STATE OR COUNTRY) Norway.

14. INFORMANT Mrs Clara M. Hansen.
(Address) 1420 Sycamore Street.

15. FILED 11 1930 John G. Galt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10, 1930¹⁹

17. I HEREBY CERTIFY, That I attended deceased from Viewed......, 19....., to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 6:40 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractured skull, result of Auto Accident at 22nd & Pacific

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS no
(Signed) Bill Tadlock Coroner M. D.
6/11, 1930 (Address) St Joseph Mo.

*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 Ashland Cemetery. DATE OF BURIAL June 12, 19 30
20. UNDERTAKER W. Sidupfaden ADDRESS 1802 Union St.

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

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JAMES EARL RAY
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is very good

1945
JAMES EARL RAY
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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Buchanan Registration District No. 83 File No. _____
 Township Doe Primary Registration District No. 1001 Registered No. 683
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

James Lee Hansen
 (a) Residence, No. _____ St. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
- (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) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14.

INFORMANT _____
 (Address) _____

15.

FILED 8/6/30 J. G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractured skull
result of auto accident
between two autos at 22nd
Pacific St. Joplin, Mo.

CONTRIBUTORY (SECONDARY) _____
 (duration) _____

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

Every item of information should be carefully supplied. Any item would be stated EXACTLY. PHYSICIAN should state EXACT STATEMENT OF OCCUPATION. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATION UNTIL THEY ARE COMPLETE AS PRESENTED BY LAW.

SUPPLEMENTARY

100-100000

S-18656

100-100000

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