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REGD JUN 14 1938MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

19853

Do not use this space.

## 1. PLACE OF DEATH

(a) County Wright Registration District No. 908  
 (b) Township Mountain Grove Primary Registration District No. 4549 Registered No. 30  
 (c) City MOUNTAIN GROVE (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 7 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bernice Jude Hansen 525

(a) Residence, No. 646 W. 1st St. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 12, 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
14 4 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. School girl  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Davenport, Iowa13. NAME Peter Hansen14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Valentine, Neb.15. MAIDEN NAME Vera S. Nicholson16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Quaker, Neb.17. INFORMANT (ADDRESS) Mrs Peter Hansen18. BURIAL, CREMATION, OR REMOVAL PLACE Hill Crest DATE 5-30-193819. FUNERAL DIRECTOR (ADDRESS) Botten Funeral Home20. FILED 5-31, 1938 Bernice Montgomery Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 27, 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at 9:30 A. m.

The principal cause of death and related causes of importance were as follows:

Traumatic Peritonitis Date of onset \_\_\_\_\_Other contributory causes of importance: Probably typhoid fever

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Culture Was there an autopsy? yes23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?  Date of injury \_\_\_\_\_, 19\_\_\_\_Where did injury occur?  (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury 

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_

(Signed) George Stoffe (Colonel)(Address) Mrs Grove

STATEMENT BY LICENSED EMBALMER

I, George Staff, Licensed Embalmer No. 3161

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed George Staff

Licensed Embalmer No. 3161

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

Miss Wood —  
do not copy info.  
on supp on orig.  
cert

REC'D JUN 14 1930

## MISSOURI STATE BOARD OF HEALTH

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## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County WRIGHTRegistration District No. 908

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 4549Registered No. 30City Mountain Grove (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME BONNIE JUNE 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

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.  
14 8 15OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Registrar \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-27-193022. I HEREBY CERTIFY, That I personally investigated \_\_\_\_\_on above date at Mountain Grove, Mo.  
I have occurred on the day stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

Trauma caused by \_\_\_\_\_ Date of onset \_\_\_\_\_

swedish massage for sudden entrapment about five days prior to death.

Other contributory causes, if importance: \_\_\_\_\_

Non periperalName of operation NMO Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Thos W Chamberlain(Address) Ward 908Sub-board of Health6-8-30