

REC'D SEP 7 1939

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

29530

Do not use this space.

## 1. PLACE OF DEATH

(a) County Lafayette Registration District No. 460  
(b) Township Dover Primary Registration District No. 5623  
(c) City Higginsville or Confederate Home (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs Mary Shults Hanson

(a) Residence, No. Confederate Home of Mo. 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 (*write the word*) Widowed  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec, 7, 1850  
7. AGE YEARS 88 MONTHS 8 DAYS 8 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
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 \_\_\_\_\_  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

12. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) \_\_\_\_\_  
13. NAME Unknown  
14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) \_\_\_\_\_  
15. MAIDEN NAME Unknown  
16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT Rimer Kirby (ADDRESS) Higginsville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Con-Home DATE 8/16/39

19. FUNERAL DIRECTOR (NAME) A. H. Hader (ADDRESS) Higginsville, Mo.

20. FILED Sept 1 1939 Jeffrey Webb Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 15 193922. I HEREBY CERTIFY That I attended deceased from Dec 36 to Aug 15, 1939

I last saw her alive on Aug 15, 1939. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

Uremia  
Chronic Myocarditis  
Arteriosclerosis  
97 C

Other contributory causes of importance:  
Senile Dementia

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? none 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? No  
If so, specify \_\_\_\_\_ (Signed) James J. Moore, M. D.  
(Address) Higginsville, Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
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.

RECEIVED  
District Health Officer No. 8,  
District File Number  
9/5/39  
Date Filed

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....  
Licensed Embalmer No.....  
P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**