

FILED APR 12 1940

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

10040

Do not use this space.

1. PLACE OF DEATH

(a) County Audrain / Registration District No. 26
 (b) Township Salt River Primary Registration District No. 3003 Registered No. 35
 (c) City Mexico (d) Street No. Audrain Hospital 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

575 Mrs. Della Hansen
 (a) Residence, No. Middletown 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>W. R. Hansen</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 23, 1860</u>		
7. AGE YEARS <u>79</u>	MONTHS <u>2</u>	DAYS <u>25</u>
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>at home</u>	
	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) <u>Ohio</u>		
FATHER	13. NAME <u>John Young</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>	
MOTHER	15. MAIDEN NAME <u>Catherine Weltner</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>	
17. INFORMANT (ADDRESS) <u>James E. Jones Middletown mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Middletown mo</u> DATE <u>3-21</u> 19 <u>40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Jones & Wells Middletown mo</u>		
20. FILED <u>Mar 19, 1940</u> <u>Blanche Neely</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 19, 1940

22. I HEREBY CERTIFY That I attended deceased from March 16, 1940 to March 19, 1940.
 I last saw him alive on March 19, 1940. Death is said to have occurred on the date stated above, at 11:00 P.M.
 The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis
General arteriosclerosis
Pulmonary Edema
 Other contributory causes of importance:
Chronic Cholecystitis

Name of operation none 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? no 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 no
 (Signed) H. P. Prashar, M. D.
 (Address) Mexico mo

RECEIVED

District Health Officer No. 10

District File Number 4-40-297

Date Filed APR 9 1940

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. 588

P. O. Address Albion 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 this body is not embalmed, above space should be left blank.