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7-39  
K23139

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD—FILE DEC 10 1940

Registration District No. 85 Primary Registration District No. 1001

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution: 523 Faraon  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 50 years  
In this community 50 years  
(Specify whether years, months or days) 2

3. (a) PRINT FULL NAME HANS IBSEN  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Dollie Ibsen  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased Dec. 26th. 1865  
(Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days 1  
If less than one day hr. min.

9. Birthplace Holstein Denmark  
(City, town, or county) (State or foreign country)

10. Usual occupation Garage Operator Owner

11. Industry or business Garage

12. Name H. Ibsen  
13. Birthplace unknown Denmark  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace unknown Denmark  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Dollie Ibsen

(b) Address 523 Faraon St. Joseph Mo.

17. (a) Removal (b) Date thereof 11-29-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation York Cem. King City, Mo.

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) 11-29-40 (b) H. Nestle Bush  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 523 Faraon  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27th.  
year 1940 hour 2. minute A. M.

21. I hereby certify that I attended the deceased from Nov 27th 40 Viewed  
to Nov 27th 40 Viewed  
that I last saw him alive on Nov 27th 40 Viewed  
and that death occurred on the date and hour stated above.

Immediate cause of death Suicide by Hanging

Due to 105

Due to 105

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations none  
Of autopsy none

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence Nov 27th 1940

(c) Where did injury occur? St Joseph, Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

(e) Means of injury Hanging  
While at work? no (Specify type of place)

23. Signature B.W. Tadlock (M. D. or other) Coroner

Address King Hill Rd Date signed 11/29/40

**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. 3955

P. O. Address St Joseph

**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, fact should be so stated above.**