

No. 2  
11-19-39  
17-31-40  
I X21462

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

Registration District No. 266

Primary Registration District No. 5373

Registrar's No. 78

1. PLACE OF DEATH

(a) County DeWitt  
(b) City or town Rural Salem Franklin  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County DeWitt  
(c) City or town Salem Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) \_\_\_\_\_  
(e) If foreign born, how long in U. S. A? 2 years

3. (a) PRINT FULL NAME Libert J. Hansen  
3. (b) If veteran,  3. (c) Social Security name war \_\_\_\_\_ No. 1

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 2 day 8  
year 1940 hour \_\_\_\_\_ minute 70 - M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife William 6. (c) Age of husband or wife if 34 years  
G. Hansen alive 11 1929  
7. Birth date of deceased (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him  alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years 11 Months 2 Days 23 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Body Buried To Death by House Burning During which Body Due to in House at Time Cremated by Fire House Burned  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 180  
Of autopsy 17

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

10. Usual occupation U

11. Industry or business \_\_\_\_\_  
12. Name William G. Hansen  
13. Birthplace Waukegan, Florida (City, town, or county) (State or foreign country)  
14. Maiden name Olive Winn  
15. Birthplace Arizona (City, town, or county) (State or foreign country)

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

16. (a) Informant Mae Masters  
(b) Address 1005 Mo.  
17. (a) Burial (b) Date thereof Nov 4 1940 (Month) (Day) (Year)  
(c) Place: burial or cremation New Hope Cemetery

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence Nov 3 - 1940  
(c) Where did injury occur? Blaine County Mo (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work no (Specify type of place) (e) Means of injury Fire

18. (a) Signature of funeral director W. H. ...  
(b) Address Salem Mo  
19. (a) Nov 4 1940 (b) F. E. ... (Registrar's signature)  
(Date received local registrar) (City, town, or county)

23. Signature W. H. Dieckman (M. D. or other) \_\_\_\_\_  
Address Salem Mo Date signed Nov 2-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 5,

District File Number 12401192

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.**