

No. 2  
1-4-41  
5-7-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10942

FILED APR 2 1943

State File No. ....

Registration District No. 240

Primary Registration District No. 5827

Registrar's No. ....

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Boonville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 M<sup>th</sup>  
(Specify whether years, months or days)

In this community 1 M<sup>th</sup>  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Boonville  
(If outside city or town limits, write "RURAL")

(d) Street No. New Boonville MO.  
(If rural, give location)

(e) Citizen of foreign country? - (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Magdelene Hanselson

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James Hanselson

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July-21-1920  
(Month) (Day) (Year)

8. AGE: Years 22 Months 6 Days 12

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace New Madrid Co. MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Housewife

MOTHER FATHER

12. Name unknown

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant James Hanselson

(b) Address Boonville MO.

17. (a) Burial (b) Date thereof 2-4-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boonville

18. (a) Signature of funeral director Y. C. Dean

(b) Address Boonville MO.

19. (a) Feb 9-43 (b) Wm. H. Barrett  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb- day 3  
year 1943 hour 2 minute 30 A. M.

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.

Immediate cause of death Lung abscess

Due to pneumonia

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. H. Barrett (M. D. or other) MD  
Address New Madrid Date signed 2/4/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1376

(Licensed Embalmer's Statement on Reverse Side)

~~APR 21 1943~~

MAR 17 1943

COPIED

APR 8 1943

**STATEMENT BY LICENSED EMBALMER**

*not*

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 *Nail C. Deane*

Licensed Embalmer No. *3941*

P. O. Address *Portagville, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10942

Registration District No. 240

Primary Registration District No. 5827

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Rural  
(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 \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL.")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Magdelaine Havelson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 6  
(Month) (Day) (Year)

Immediate cause of death lung abscess Duration \_\_\_\_\_

8. AGE: Years 22 Months 6 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, and county) (State or foreign country) mo.

Due to Pneumonia  
Broncho-pneumonia

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN 107  
Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature B. Hellenstein M.D. (M. D. or other) \_\_\_\_\_  
Address New Madrid, Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S/10942