

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 3 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36430

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10104**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1350 Cockrill Ave.,
(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 _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1350 Cockrill Ave.,**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Dorothea C. Hansen.**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Fred Hansen** 6. (c) Age of husband or wife if alive **85** years

7. Birth date of deceased **Aug. 28, 1856.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 **2** **20** hr. min.

9. Birthplace **Den Mark 4**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Charles Hansen**

13. Birthplace **Den Mark 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Den Mark 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Fred Hansen**

(b) Address **1350 Cockrill Ave.,**

17. (a) **Burial** (b) Date thereof **Nov. 19/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lakewood Park Cem.,**

18. (a) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiamont Ave.,**

19. (a) **NOV 18 1943** (b) **J. J. Prudeak**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **17**
year **1943** hour **12.35** minute **A.M.** M.

21. I hereby certify that I attended the deceased from **Sept 27** 1943 to **Nov 17** 1943
that I last saw her alive on **Nov 16** 1943
and that death occurred on the date and hour stated above.

Immediate cause of death **CARDIAC DECOMPENSATION** Duration **3 yrs**

Due to **Chronic Myocarditis** **5 yrs**

Due to **Diabetes Mellitus**

Other conditions **Diabetes Mellitus**
(Includes pregnancy within 3 months of death)
HYPERTENSION Arteriosclerosis

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)
(c) Means of injury _____

23. Signature **J. J. Prudeak** (M. D. or other) **MD**
Address **5930 Southwest Ave** Date signed **11-18-43**

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

MOTHER FATHER

Dr. H.F. Cleveland
5930 Southwest Ave.,
HI. 0750.
8-11 or 7-8 P.M.

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

John Ogroski

Licensed Embalmer No. 3398.

P. O. Address St. Louis, 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.