

S. No. 2
M-5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4202
Registrar's No. 5002

FILED DEC 22 1943

Registration District No. 749 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Devine Bros. Clinic 918 Oak St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
(Specify whether
In this community 17 days
years, months or days)

3. (a) PRINT FULL NAME Albert Hansen
3. (b) If veteran, name war No.
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 Albertina Hansen
6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased: June 9 1867
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 4
If less than one day 18 hr. 0 min.

9. Birthplace: Bucklin Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

MOTHER FATHER
11. Industry or business
12. Name Ole Hansen
13. Birthplace Norway
(City, town, or county) (State or foreign country)
14. Maiden name Hannah Stevenson
15. Birthplace Sweden
(City, town, or county) (State or foreign country)

16. (a) Informant Ole T. Hansen
(b) Address Courtland, Kansas
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-28-43
(Month) (Day) (Year)
(c) Place: burial or cremation Jamestown, Kansas
18. (a) Signature of funeral director Freeman Mortuary
(b) Address Kansas City Mo.
19. (a) 11-27-43 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County 14
(c) City or town Courtland
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 2

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 27
year 1943 hour 10:19 minute 11 M.

21. I hereby certify that I attended the deceased from No. 4th 31
1943 No. 1 27th 1943
that I last saw him alive on Nov 26 27 1943
and that death occurred on the date and hour stated above.

Immediate cause of death General decline from Cerebrolythotomy.
Due to Cerebrolythotomy. 17 days
Due to _____

Other conditions (Include pregnancy within 3 months of death) 35 days

Major findings: Of operations Cerebrolyth
Of autopsy _____

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) _____
(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?
(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature G. M. Jacques (M. D. or other)
Address 918 Oak St. C. Mo. Date signed 11-27-43

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

S. Jacques
2-2-11

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 *Walter H. Erwin*

Licensed Embalmer No. *4352*

P. O. Address *Kansas City, 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.