

FILED FEB 24 1944

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

618

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City Mo  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Home 3506 Woodland 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 26 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3506 Woodland Ave  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_ no

3. (a) PRINT FULL NAME Mrs Eva.C.Hanson

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, 2 divorced Widowed

6. (b) Name of husband or wife Henry Hanson (Deceased) (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 15th 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 9 20 hr. \_\_\_\_\_ min.

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

10. Usual occupation Home

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

12. Name G Smith

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

14. Maiden name Anna Marvle

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

16. (a) Informant Miss Mabel Hanson

(b) Address 3506 Woodland Ave

17. (a) Burial (b) Date thereof 2-7-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director Eular Funeral Home

(b) Address 1800 Linwood Blvd

19. (a) 2-7-44 (b) N.C. Brown  
(Date received local relatives) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5th  
 year 1944 hour 2 minute 45A.M.

21. I hereby certify that I attended the deceased from Apr 8 1942 to Feb 5 1944  
 that I last saw her alive on Jan 29 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition Duration

Due to Senility

Due to Heart 2-3 weeks

Other conditions General weakness  
(Include pregnancy within 3 months of death)

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

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

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?

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

23. Signature Hugh A. Vestring (M.D. or other) \_\_\_\_\_

Address 803 Chestnut St Date signed 2-5-44

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

Dr. H. A. Gestring  
Wirthman Bg  
31st & Troost Ave  
Phone Va 6400

**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 *Glen E. Heck*

Licensed Embalmer No. *4063*

P. O. Address *1600 Linwood, Kansas*

**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.**

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Hannover city  
(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

3. (a) PRINT FULL NAME Eva C. Hanson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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)

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

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

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

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

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 4-5-46 to 4-5-46 that I last saw him alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death senility

Due to fall

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

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

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

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_ Address 303 North Main Bldg Date signed 9-3-46

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

SUPPLEMENTAL

6101