

FILED OCT 13 1944

Registration District No. **72**

Primary Registration District No. **1000**

Registrar's No. **998**

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2609 Pacific
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 70 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 2609 Pacific
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME EMILY MAY TEIGH
 (b) If veteran, name war none
 (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 4
 year 1944 hour 1 minute 20 P. M.

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced divorce
 (b) Name of husband or wife unknown
 (c) Age of husband or wife if alive 1 years
 7. Birth date of deceased May 1 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 11 1944 to Oct 4 1944
 that I last saw her alive on Oct 4 1944
 and that death occurred on the date and hour stated above.

8. AGE: Years 79 Months 5 Days 3
 If less than one day hr. min.

Immediate cause of death Chronic Myocarditic Hypertension
Pneumonia
 Due to Chronic Myocarditic Hypertension
 Due to Pneumonia

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

Other conditions none
(Include pregnancy within 3 months of death)

10. Usual occupation at home
 11. Industry or business at home
MOTHER FATHER { 12. Name Joseph Hansen
 13. Birthplace Cologne Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Rebecca Thompson

Major findings: none
 Of operations none
 Of autopsy none
PHYSICIAN
 Underline the cause to which death should be charged statistically.

15. Birthplace Chester Penn.
(City, town, or county) (State or foreign country)
 16. (a) Informant Mr. Lee R. Hansen
 (b) Address 2609 Pacific
 17. (a) burial (b) Date thereof 10/6/44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Mora

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 fall

18. (a) Signature of funeral director Walter B. Hale & Bowman
 (b) Address 319 South 10th
 19. (a) 10/6/44 (b) Walter B. Hale
(Date received local registrar) (Registrar's signature)

23. Signature Walter B. Hale (M. D. or other) _____
 Address 2802 Julia Date signed 10/9/44

1311

H. J. Hansen

11/14/13
14
11/14/13
14

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 *Edward J. Murray*
Licensed Embalmer No. 1710
P. O. Address *St. George, 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.