

S. No. 2
OM-8-43
v. 5-17-39
-1 X37823

35259

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 4 1944
Registration District No. 577

Primary Registration District No. 3070

Registrar's No. 2223

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

1. PLACE OF DEATH:

(a) County ST LOUIS

(b) City or town WEBSTER GROVES
(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 69 YRS years, months or days)

3. (a) PRINT FULL NAME CATHERINE NISSEN HANSEN

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 WIDOWED

6. (b) Name of husband or wife GEORGE HANSEN

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

7. Birth date of deceased JAN 28 1859
(Month) (Day) (Year)

8. AGE: Years 86 Months 9 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name PETER NISSEN BRAROE

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

14. Maiden name MARION FRIES

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

16. (a) Informant _____

(b) Address _____

17. (a) BURIAL (b) Date thereof NOV 3 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Pauls Lutheran Cemetery

18. (a) Signature of funeral director Parker and Co

(b) Address Widger Bros mo

19. (a) NOV 1 1944 (b) E. H. Molnar M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS

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

(d) Street No. 639 E FRISCO
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31 year 1944 hour 4 minute 40 A.M.

21. I hereby certify that I attended the deceased from Oct 29 1944 to Oct 31 1944
that I last saw her alive on Oct 30 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage with hemiplegia Duration 3da.

Due to Arteriosclerotic heart disease

Due to Senility

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 938

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 D

23. Signature Ellsworth A. Wilcox M.D. (M.D. or other) _____
Address 207 E. Big Bend Date signed 10-31-44

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.....

Leslie Welch....., Registered Apprentice No. *362*
working under my personal supervision.

Signed *E. B. Aldrich*.....

Licensed Embalmer No. *1332*.....

P. O. Address *Webster Groves*.....

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.