

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35738

FILED DEC 4 1944

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4716

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:
2513 EAST 49TH STREET
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days) 40 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY 48
(If outside city or town limits, write "RURAL")

(d) Street No. 2513 EAST 49TH STREET
(If rural, give location)

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

3. (a) PRINT FULL NAME MRS. LILLA MAY FIFIELD HANSEN

3. (b) If veteran, name war No

3. (c) Social Security No. NO. 11VE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 21⁵⁷
year 1944 hour 5 minute 30 P. M.

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MR JACOB HANSEN

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased JULY 25 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 12 1944
Nov 21 1944 to Nov 21 1944

that I last saw him on Nov 21 and that death occurred on the date and hour stated above

Immediate cause of death Carcinoma of Rectum
acute nephritis

8. AGE: Years Months Days If less than one day

73 3 27 26 hr. _____ min.

Due to arterio-sclerosis - 5 yrs

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

Due to _____

10. Usual occupation HOUSEWIFE

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

11. Industry or business _____

Major findings: Of operations no Of autopsy no

MOTHER FATHER

12. Name FRED C. FIFIELD

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

14. Maiden name UNKNOWN

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

16. (b) Informant Jacob Hansen

(b) Address 2513 E - 49 - St. No

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 24 1944
(Month) (Day) (Year)

(c) Place: burial or cremation FLORAL HILLS CEM.

18. (a) Signature of funeral director D. H. Newsomer's Sons

(b) Address 1401 BRUSH CREEK BLYD.

19. (a) 11-23-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

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 M. B. Bechtel MD (Physician) (Date) 11/22/44

Address 4000 Pa

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

By: _____
Harris Bldg. 4000 Baltimore

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 Frederic M. Colborn

Licensed Embalmer No. 3506

P. O. Address KC 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.