. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1945

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 5198

Registrar's No. 670

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: K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)

In this community: forty year

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City ?
(If outside city or town limits, write "RURAL")

(d) Street No.: 406 W. 17 St.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Hans Jensen

3. (b) If veteran, name war: no

3. (c) Social Security No. 496-09-1812

4. Sex: Male

5. Color or race: White

6. (a) ~~Single~~, widowed, ~~married~~, divorced: 2

6. (b) Name of husband or wife: Nellie Jensen

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

7. Birth date of deceased: 7 (Month) 5 (Day) 1876 (Year)

8. AGE: Years 68 69 Months 57 Days 52 If less than one day hr. min.

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

10. Usual occupation: Butcher

11. Industry or business

MOTHER FATHER

12. Name: Peter Jensen

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

14. Maiden name: Margaret Hansen

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

16. (a) Informant: Sophie Jacobson

(b) Address: 520 N. 11th Shawnee Kans.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-10-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Maple Hill Cemetery

18. (a) Signature of funeral director: Albert E. Weller

(b) Address: 2332 Monitor Place

19. (a) 2-10-45 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 7 year 1945 hour 10 minute 6 P.M.

21. I hereby certify that I attended the deceased from February 4, 1945, to February 7, 1945; that I last saw him alive on February 7, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerotic heart disease	
Due to	
Due to 93 d	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:

Of autopsy: None

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: Clark W. Seely M.D. (M. D. or other)

Address: Med. Dir. Gen'l Hosp. Date signed 2-7-45

(Licensed Embalmer's Statement on Reverse Side)

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 Jack W. Laybourne

Licensed Embalmer No. 1715

P. O. Address K. C. 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.