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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8562

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

FILED APR 10 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 320

1. PLACE OF DEATH:

(a) County Duchamp  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri Methodist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County CLINTON  
(c) City or town Plattsburg  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 1  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN HANSEN

3. (b) If veteran, name war: --- 3. (c) Social Security No. none

4. Sex M 5. Color of hair W 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife single 6. (c) Age of husband or wife if alive non years

7. Birth date of deceased Oct. 22 1862  
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 27 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Blacksmith

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

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant J. R. Fowler

(b) Address Plattsburg, Mo.

17. (a) Removal (b) Date thereof 3-19-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Plattsburg

18. (a) Signature of funeral director Jas L Martin

(b) Address Plattsburg, Mo.

19. (a) Mar. 19, 1946 (b) Plattsburg  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19 year 1946 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from 3/1/46 to 3/19/46

that I last saw him live on 3/19/46 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

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

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

Other conditions Hepatitis of Prostate Gland  
(Include pregnancy within 6 months of death)

Major findings: Of operations as above

Of autopsy 1370

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 Chas Greuber (M. D. or other) M.D.

Address St. Joseph Date signed 3/19/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

DEC 30 1945

**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

*Gas L Martin*

Licensed Embalmer No.

*4303*

P. O. Address

*Plattsburg*

**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.**