

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28556

FILED AUG 26 1947

State File No.

Registration District No.

Primary Registration District No. 3052

Registrar's No.

265

1. PLACE OF DEATH:

(a) County Peters  
(b) City or town Sedalia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Bathwell Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life years, months or days

3. (a) PRINT FULL NAME Hannah M. Hansam  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced WID  
6. (b) Name of husband or wife James A. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 3 1891 (Month) (Day) (Year)

8. AGE: Years 55 Months 11 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Smithton Mo (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

12. Name William Broschur  
13. Birthplace Morgan Co. Mo (City, town, or county) (State or foreign country)  
14. Maiden name Rebecca G. Galt  
15. Birthplace Morgan Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs G. W. Peak  
(b) Address Sedalia Mo.

17. (a) Burial (b) Date thereof 8-4-47 (Month) (Day) (Year)  
(c) Place: burial or cremation Smithton

18. (a) Signature of funeral director Geo. D. Dillard  
(b) Address Sedalia Mo.

19. (a) 8-4-47 (b) Betty Yeager (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Peters 80  
(c) City or town Sedalia 6  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1513 E Broadway 0  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2  
year 1947 hour 10 minute - A.M.

21. I hereby certify that I attended the deceased from May 47 to Aug 2 19 47  
that I last saw him alive on August 2 19 47  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage  
Due to arteriosclerosis, advanced

Due to \_\_\_\_\_  
Other conditions Hypertension, essential  
(Include pregnancy within 6 months of death)

Major findings: Of operations none  
Of autopsy none 83A  
PHYSICIAN \_\_\_\_\_ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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)  
(c) Means of injury \_\_\_\_\_  
23. Signature Chas. Gordon Skiffach (M. D. or other) MD  
Address Sedalia Missouri Date signed Aug 4-47

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8.

District File Number.....

Date Filed.....

AUG 26 1947

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.....

*John A. Cantlon*

Licensed Embalmer No. *4387*

P. O. Address..... *Sedalia, 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.