

No. 2
-1/47
-17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8418**

FILED MAR 30 1948

Registrar's No. **219**

Registration District No. **128**

Primary Registration District No. **2000**

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **103 days 23 hours**
(Specify whether
In this community **Same**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Iowa** (b) County **Hardin 999**
(c) City or town **Alden**
(If outside city or town limits, write "RURAL")
(d) Street No. **None**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Willard H. Hansen**

3. (b) If veteran, name war **VV II** 3. (c) Social Security No. **?**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Elsie** 6. (c) Age of husband or wife if alive **36** years
7. Birth date of deceased **June 3, 1915**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 8 9 23 hr. min.

9. Birthplace **Latimer, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Truck driver**

11. Industry or business
12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Clinical Records, V.A.**
(b) Address **Hospital**

17. (a) **Removal** (b) Date thereof **3-15-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Iowa Falls, Ia.**

18. (a) Signature of funeral director **Gorman Schiefelbusch**
(b) Address **Springfield, Mo.**

19. (a) **3-15-48** (b) **W. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **13**
year **1948** hour **11** minute **05** P.M.

21. I hereby certify that I attended the deceased from **December 1, 1947** to **March 13, 1948**
that I last saw him alive on **March 13, 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculosis, pulmonary, chronic, reinfection type, far advanced, active.**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **13B**
Of autopsy
Duration
PHYSICIAN
Underline the cause of 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)
(e) Means of injury
23. Signature **P. C. Smith** (M. D. or other)
Address **VAH, Springfield, Mo.** Date signed **3-15-48**

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

MOTHER FATHER

JUL 8 1949

VS AUG 31 1959

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

Harry Lyle Registered Apprentice No. 479
working under my personal supervision.

Signed L. Duane Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield 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.