FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11565

FILED APR 26 1948

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 460

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rose Leon Nursing Home
624 Prospect, Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 10 days (Specify whether years, months or days)
In this community: 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No.: 3307 SEneca, Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Myrtle M. Hanson
3. (b) If veteran, name war: No
3. (c) Social Security No.:
4. Sex: Female
5. Color or race: white
6. (a) Single, widowed, married, divorced: single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: October (Month) 14 (Day) 1882 (Year)
8. AGE: Years 65 Months 6 Days 5 — If less than one day: hr. min.
9. Birthplace: Conway (City, town, or county) Iowa (State or foreign country)
10. Usual occupation: Reg. Nurse
11. Industry or business:
FATHER 12. Name: Robert M. Hanson
13. Birthplace: Unk. (City, town, or county) Illinois (State or foreign country)
MOTHER 14. Maiden name: Anna Hosford
15. Birthplace: Unk. (City, town, or county) Illinois (State or foreign country)
16. (a) Informant: Mrs. Charles Terrell
(b) Address: Bedford, Iowa
17. (a) removal (Burial, cremation, or removal) (b) Date thereof: 4-21-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Bedford Iowa
18. (a) Signature of funeral director: Stamey Funeral Home
(b) Address: St. Joseph, Missouri
19. (a) 4/23/48 (Date received local registrar) (b) E. B. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1948 hour 7 minute 45 a.m.
21. I hereby certify that I attended the deceased from Apr. 1, 19 48 to Apr. 19, 19 48 that I last saw her alive on Apr. 17, 19 48 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial failure	2 days
Due to: Generalized carcinomatosis	1 yr.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

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: (M.D. or other)
Address: 411 Kirkpatrick Bldg. St. Joseph, Mo. Date signed: 4/19/48

Jefferson City Printing Co. — Licensed Embalmer's Statement on Reverse Side

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

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: Charles M. Harman

Licensed Embalmer No. 4487

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 42 Primary Registration District No. 1020 Registrar's No. 460

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Myrtle M. Hanson

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 14 (Day) 1888 (Year)

8. AGE: Years 65 Months 6 Days 5 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 19
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Generalized carcinomatosis	6 mo.
Due to carcinoma of breast	1 yr.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

50

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 W. M. Toothaker (M.D. or other)

Address 411 Kirkpatrick Date signed 5/3/48

SUPPLEMENTARY

S-11565