

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **1266**
208

FILED FEB 11 1949

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MONTANA b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SCOBEE	
c. LENGTH OF STAY (In this place) 12 DA.		d. STREET ADDRESS (If rural, give location) 2	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) EMMA b. (Middle) PETRIE c. (Last) HANSON			4. DATE OF DEATH (Month) (Day) (Year) JAN-17-1949		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH FEB-27-1880		9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) NORWAY		12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME EDWARD ISRAELSON		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE HANS HANSON	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Guy May Williamson ADDRESS Pana	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC Decompression - 5 mo.		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CARDIAC FIBROSIS - Atherosclerosis 6 mo.			
		DUE TO (c) CORONARY AORT SCLEROSIS 6 mo.			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. PROBABLE OCCUSION Uremia		1 mo.	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.1		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? D	
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22. I hereby certify that I attended the deceased from 1-5-1949 to AUTOPSY, ONLY, that I last saw the deceased alive on 1-19-49, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE F.C. Helwig (Degree or title)		23b. ADDRESS St. Louis, Mo. K.C. Mo.		23c. DATE SIGNED 17 Jan 49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-17-49		24c. NAME OF CEMETERY OR CREMATORY Scobey Cem.	
24d. LOCATION (City, town, or county) (State) Plenty Wood, Mont.					

DATE REC'D BY LOCAL REG. 1-17-49		REGISTRAR'S SIGNATURE Geraldine Helmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS D. W. Newcomer's Sons K.C. Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10.48

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Robert Ray

Signed.....

Student Embalmer

Licensed Embalmer No. *4182*

P. O. Address *Kansas City, 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.