

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35198**  
Registrar's No. **9128**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>5042 Winona Ave.</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOSEPH</b> b. (Middle) <b>R.</b> c. (Last) <b>HANLEN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 23 1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 27, 1896</b>
9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman-Public Service Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Sullivan, Mo.</b>
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <b>Patrick Hanlen</b>	
13b. MOTHER'S MAIDEN NAME <b>Ellen Ford</b>		14. NAME OF HUSBAND OR WIFE <b>Corinne Hanlen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>World War I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <b>Corinne Hanlen</b>		ADDRESS <b>5042 Winona Ave.</b>	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cocciemia</b> ANTECEDENT CAUSES <b>Ca of Pancreas</b> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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) <b>Hot Springs Mo.</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>15 ft. fall</b>	
22. I hereby certify that I attended the deceased from <b>10-2-49</b> , to <b>10-23-49</b> , that I last saw the deceased alive on <b>10-23-49</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Carl J. Kees M.D.</b>		23b. ADDRESS <b>St. Louis, Mo.</b>	
23c. DATE SIGNED <b>10-24-49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct. 26, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
DATE REC'D BY LOCAL REG. <b>OCT 24 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Laster</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b> ADDRESS <b>4228 S. Kingshighway Bl</b>	

NOV 7 1940

500 E. W. 2nd St. St. Paul, Minn.

**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.

Student .....  
Student Embalmer

Signed Richard W. Stovesand

Licensed Embalmer No. 4007

P. O. Address.....

**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.