

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6439

State File No. ....

FILED MAR 5 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1215**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Sangamon</b>	
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>Springfield</b> <b>8120</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>DePaul Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>Y</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>John</b>	b. (Middle) <b>A.</b>	c. (Last) <b>Hanselman</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 6, 1952</b>
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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>Dec. 5, 1907</b>	9. AGE (In years last birthday) <b>44</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Shop</b>	11. BIRTHPLACE (State or foreign country) <b>Springfield, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Henry anselman</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Ambrose</b>	14. NAME OF HUSBAND OR WIFE <b>Pauline</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>James Hanselman, Springfield, Ill.</b>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Hypertension</b>		
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 type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>321X</b>
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22. I hereby certify that I attended the deceased from **Jan. 15<sup>th</sup> 1952** to **Feb. 6**, 1952, that I last saw the deceased alive on **Jan. 6**, 1952, and that death occurred at **5:30** p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>539 N. Grand St. Springfield, Ill.</b>	23c. DATE SIGNED <b>2/7/52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-6-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Springfield, Ill.</b>	24d. LOCATION (City, town, or county) (State) <b>Springfield, Ill.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 7 1952</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	ADDRESS
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(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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

*John J. Harris*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4108*

P. O. Address *J. Harris MD*

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.