

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **18054**
2499

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>4 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1629 Summitt</u>				d. STREET ADDRESS (If rural, give location) <u>1629 Summitt</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u>		b. (Middle) <u>J.</u>		c. (Last) <u>Hanson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 15 1953</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married 1</u>		8. DATE OF BIRTH <u>November 23 1880</u>	
9. AGE (In years last birthday) <u>72</u>		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 18 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tinner & Packer</u>		11. BIRTHPLACE (State or foreign country) <u>Stanhope Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Hanson</u>		13b. MOTHER'S MAIDEN NAME <u>Ingeburg Hartness</u>		14. NAME OF HUSBAND OR WIFE <u>Mabel Hanson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Mabel Hanson - 1629 Summitt</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of the Esophagus</u> ANTECEDENT CAUSES Morbid 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.				INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>150X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 1</u> , 19 <u>53</u> , to <u>May 15</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>53</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John B. Caldwell MD</u>		23b. ADDRESS <u>306 E. 12 St Kansas City, Mo.</u>		23c. DATE SIGNED <u>5/15/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>May 16 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Smt Hope Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Kansas</u>	
DATE REC'D BY LOCAL REG. <u>5-15-53</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wilko Funeral Home - 2315 Linwood St</u>			

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.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed *Chas E Weeks*

Licensed Embalmer No *2644*

P. O. Address *189710*

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.