

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31812

FILED SEP 24 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4344

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) 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. CITY OR TOWN <u>Kansas City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>20 yrs</u>		e. STREET ADDRESS (If rural, give location) <u>4220 East 56 St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4220 East 56 St.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Julia</u>		b. (Middle)	c. (Last) <u>Hansen</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 1 1953</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Mar. 29 1881</u>	9. AGE (In years last birthday) <u>82</u> If UNDER 1 YEAR Months Days If UNDER 4 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Moline Illinois /</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Peter Christopher</u>		13b. MOTHER'S MAIDEN NAME <u>No record</u>		14. NAME OF HUSBAND OR WIFE <u>Marcus Hansen</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hazel Sargent 4220 East 56 St. K.C. Mo.</u>		
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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 <u>3 Weeks</u> <u>Over 8 months</u> <u>153 X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malnutrition</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Caecum</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>			

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?
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22. I hereby certify that I attended the deceased from Dec 27, 1952, to Sept 1, 1953, that I last saw the deceased alive on Aug 27, 1953, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Glen H. Broyles</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>1232 Professional Bldg.</u>	23c. DATE SIGNED <u>Sept. 2-1953</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept. 4 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>9-4-53</u>	REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mrs C.L. Forster 918 Brooklyn Kas. City, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....
Signature of Student Embalmer

Signed *J. Vigil Herrick*

Licensed Embalmer No. *3590*

P. O. Address *A. C. M.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.