

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7824**

FILED APR 4 1955

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **281**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Minnesota b. COUNTY Hennepin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY OR TOWN Minneapolis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 week		e. STREET ADDRESS (If rural, give location) 4528 York Ave, South	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Burge Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) ROY	b. (Middle) F.	c. (Last) HANCE	4. DATE OF DEATH (Month) (Day) (Year) March 27 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 6, 1913	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and State or Foreign Country) Maple Lane, Minnesota /	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Mose Hance	13b. MOTHER'S MAIDEN NAME Ida Courchane	14. NAME OF HUSBAND OR WIFE Cecelia Capra Hance
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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) Yes WW II	16. SOCIAL SECURITY NO. Yes	17. INFORMANT'S SIGNATURE OR NAME Mrs Cecelia Hance, Minneapolis, Minn.	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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Concussion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		E866X 39	

19a. DATE OF OPERATION 3/24/55	19b. MAJOR FINDINGS OF OPERATION Brain laceration + hemorrhage	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE ACCIDENT	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) air plane	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Rural Center Twp, Greene, MO Missouri
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) March 20, 1955 10:45p	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Air plane crash
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22. I hereby certify that I attended the deceased from **3-20, 1950, to 3-27, 1955**, that I last saw the deceased alive on **3-28, 1955**, and that death occurred at **8:05P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) IR D Dimeau O.M.D.	23b. ADDRESS Springfield, MO	23c. DATE SIGNED 3-28-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE March 29, 1955	24c. NAME OF CEMETERY OR CREMATOR Unknown	24d. LOCATION (City, town, or county) (State) Minneapolis, Minnesota
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DATE REC'D BY LOCAL REG. 3-28-55	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Alma Schmeier	ADDRESS Springfield, MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 8 1955

JUL 9 1955

APR 5 1955

APR 12 1955

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. 515 working under my personal supervision..

Student Murray Wilson
Signature of Student Embalmer

Signed Bernard F. Wright

Licensed Embalmer No. 429

P. O. Address Spring

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.