

FILED JUL 11 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19339

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 531

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Brookfield</u>		c. CITY OR TOWN <u>Browning</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) _____		f. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McLarney Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Hans</u> b. (Middle) <u>Christian</u> c. (Last) <u>Hanson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7 - 5 - 55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 6, 1885</u>	9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR Months Days IF UNDER 24 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>Farmer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>1</u>

13a. FATHER'S NAME <u>Hans Fredrick Hanson</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Nelson</u>		14. NAME OF HUSBAND OR WIFE <u>Margaret Hanson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>86128334</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Margaret Hanson Browning</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive heart failure</u> ANTECEDENT CAUSES DUE TO (b) <u>Emphysema</u> DUE TO (c) <u>Bronchial asthma 4341</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u> <u>10 years</u>
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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) _____
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? _____

22. I hereby certify that I attended the deceased from 4/3, 1953, to 7/5, 1952, that I last saw the deceased alive on 7/6, 1955, and that death occurred at 6:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>D. S. Bohlen M.D.</u>	23b. ADDRESS <u>211 Fern Brookfield Mo</u>	23c. DATE SIGNED <u>7/6/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-6-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Knifong</u>	24d. LOCATION (City, town, or county) (State) <u>Browning rural Mo</u>
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DATE REC'D BY LOCAL REG. <u>7-9-55</u>	REGISTRAR'S SIGNATURE <u>Walter B. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wade Funeral Home Browning</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 5 1955

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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 *Gerald I. Mad*.....

Licensed Embalmer No. *41*

P. O. Address *Brown*

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.