

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44245

FILED JAN 7 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 3010

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jennings		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Jennings Hill		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5263 Hodiament Avenue		Length of stay in lb 10 Yrs	d. STREET ADDRESS (If outside, give location) 5263 Hodiament Ave.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NORA Middle M. Last HANSON			4. DATE OF DEATH Month Dec. Day 18th Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6th, 1884	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Laramore			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Mabel Cottrell, 5263 Hodiament Ave. 20		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive cerebrovascular disease DUE TO (c) Arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH Hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 8:30A Month Feb 2, 1957 Day 1957 Year 1956 a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Louis, Missouri	
21. I attended the deceased from Feb 2, 1957 to December 15, 1956 and last saw her alive on December 12, 1956 Death occurred at 8:30A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Robert S. Weinpaus M.D.			22b. ADDRESS ROBERT S. WEINPAUS, M.D. 508 NORTH GRAND ST. LOUIS, MO.		22c. DATE SIGNED December 1956
23a. BURIAL-CREATION, REMOVAL (Specify) BURIAL	23b. DATE 12/21/56	23c. NAME OF CEMETERY OR CREMATORY Memorial ark Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, INC., St. Louis, 15, Mo.		25. DATE RECD. BY LOCAL REG. 12-21-56		26. REGISTRAR'S SIGNATURE Herbert R. Dumble M.D.	

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service
300 156
All diseases in Part I must be casually related.
Coroner cannot certify to a death due to natural causes.
No symptoms will be listed.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

89.

10:30 AM to 1:00PM Wednesdays,
10:30 AM to 5:00PM Daily exc. Wed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John A. Medina*.....
Licensed Embalmer No. *41*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.