

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2772

FILED JAN 25 1957

STATE FILE NUMBER

73

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 73

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis Mo.</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Masonic Home of Mo.</i>		d. STREET ADDRESS (If outside, give location) <i>3387 Shenandoah</i>	
3. NAME OF DECEASED (Type or print) First <i>HANS</i> Middle <i>Peter</i> Last <i>HANSEN</i>		4. DATE OF DEATH Month <i>JAN.</i> Day <i>2</i> Year <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 1, 1878</i>
9. AGE (In years last birthday) <i>78</i>		IF UNDER 1 YEAR Months <i>9</i> Days <i>1</i>	IF UNDER 24 HRS. Hours <i>1</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (City and state or country) <i>Council Bluffs Iowa</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Hans Peter Hansen</i>	
14. MOTHER'S MAIDEN NAME <i>Inger Marie Nelsen</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service. <i>No</i>	
16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Masonic Home of Missouri</i> <i>Paul Robertson</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocarditis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>Advanced arteriosclerosis</i>			<i>10 yrs.</i>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			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 _____ a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. CITY, TOWN, OR LOCATION <i>St. Louis</i>	20f. COUNTY <i>St. Louis</i>		
20g. STATE <i>Mo.</i>			
21. I attended the deceased from <i>12-25-56</i> to <i>1-2-57</i> and last saw <i>her</i> alive on <i>1-1-57</i> Death occurred at <i>4:15 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Harold E. Walters M.D.</i>		22b. ADDRESS <i>3720 Washington St. Louis Mo.</i>	
22c. DATE SIGNED <i>1-3-57</i>		22d. SIGNATURE <i>Carl Smith M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>1-5-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Laurel Hill Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Mo.</i>
24. FUNERAL DIRECTOR <i>Albert H. Hoppe, 4700 Washington Blvd.</i>		25. DATE RECD. BY LOCAL REG. <i>JAN 4 1957</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare Public Service
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1-56
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *John J. Harris* Licensed Embalmer No. *410*

P. O. Address *St. Louis*

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

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