

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

40368  
STATE FILE NUMBER  
5115

FILED NOV 20 1957

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

S. 300  
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen'l Hosp. #1</b>			Length of stay in lb <b>30 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>2537 Troost</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>A.</b> Last <b>Hanson</b>				4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>1957</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 3rd. 1915</b>		9. AGE (In years last birthday) <b>42</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nite Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Troost Arms Apt</b>		11. BIRTHPLACE (City and state or country) <b>Higginsville Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			
13a. FATHER'S NAME <b>James W. Hanson</b>			13b. MOTHER'S MAIDEN NAME <b>Eva May Klein</b>			14. NAME OF HUSBAND OR WIFE <b>Ann Hanson</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Hettie Cole. 2537 Troost</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding esophageal varices</b>							INTERVAL BETWEEN ONSET AND DEATH  <b>5810</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Cirrhosis of liver</b>								
DUE TO (c)										
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 checked="" type="checkbox"/> NO <input 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 <b>4:33 A.</b> Month <b>Oct.</b> Day <b>24</b> Year <b>1957</b>										
20d. INJURY OCCURRED WHILE AT <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		COUNTY		STATE		
21. I attended the deceased from <b>Oct. 24, 1957</b> to <b>Nov. 1, 1957</b> and last saw <sup>him</sup> <b>alive</b> on <b>Nov. 1, 1957</b> Death occurred at <b>4:33 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <b>24th &amp; Cherry</b>		22c. DATE SIGNED <b>11-1-57</b>
23a. BURIAL CREMATION, (Specify) <b>Burial</b>		23b. DATE <b>Nov. 3rd, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Higginsville, Mo.</b>		23d. LOCATION (City, town, or county) (State) <b>Higginsville, Mo.</b>					
24. FUNERAL DIRECTOR <b>Farp &amp; Sons</b> ADDRESS <b>Kansas City, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>11-2-57</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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

*James P. Kemp*  
Licensed Embalmer No. 2955  
P. O. Address *K.C. 510*

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.