

Health,  
& Welfare  
S. Public  
Health Service

FILED JAN 8 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44394  
STATE FILE NUMBER  
6071

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jaydonatta</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Northeast Restorium 16 Mo.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>3240 Norledge</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>John</u> Last <u>Hansmann</u>			4. DATE OF DEATH <u>Dec. 21, 1957</u> Month Day Year		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1873</u>	9. AGE (In years last birthday) <u>84</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>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Packing House</u>		11. BIRTHPLACE (City and state or country) <u>Paola, Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Conrad Hansmann</u>		13b. MOTHER'S MAIDEN NAME <u>Henrietta Glasner</u>	
14. NAME OF HUSBAND OR WIFE <u>Maude Emily</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>510-07-3131</u>	
17. INFORMANT <u>Mrs. Hazel Copple</u>		Address <u>Kansas City, Ks</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>4:30</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Kansas City</u>	
20f. CITY, TOWN, OR LOCATION <u>Jackson</u>		COUNTY <u>Jackson</u>		STATE <u>Mo</u>	
21. I attended the deceased from <u>Jan 1957</u> to <u>Dec 1957</u> and last saw him alive on <u>Dec 19 1957</u> Death occurred at <u>11:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. L. Shireman</u> (Degree or title)		22b. ADDRESS <u>4606 St John Kc Mo</u>		22c. DATE SIGNED <u>12-22-57</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>12-23-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery Kansas City, Kansas</u>	
23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>		24. FUNERAL DIRECTOR <u>R. A. Fulton, Kansas City, Kansas</u>		25. DATE RECD. BY LOCAL REG. <u>12-22-57</u>	
26. REGISTRAR'S SIGNATURE <u>Iveva Minshall</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

K. L. Shireman

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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 Ralph Fulton

Licensed Embalmer No. 3035

P. O. Address K. P. K.

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.