

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029112

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3824

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>JACKSON</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>RESEARCH HOSPITAL</u>		Length of stay in 1b <u>33 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>601 EAST 61ST STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE MARGARET HANSEN</u>			4. DATE OF DEATH Month Day Year <u>AUGUST-7-1958</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH-25-1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STENOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.B.C. STORAGE CO.</u>	11. BIRTHPLACE (City and state or country) <u>CARROLL COUNTY MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JACOB WOHLGEMUTH</u>	
13b. MOTHER'S MAIDEN NAME <u>MARGARET HENDERSON</u>		14. NAME OF HUSBAND OR WIFE <u>CLARENCE E. HANSEN</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>487-09-2802</u>	17. INFORMANT Address <u>CLARENCE E. HANSEN 601 EAST 61ST STREET KANSAS CITY, MISSOURI</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>Metastatic Carcinoma (generalized)</u> DUE TO (b) <u>Carcinoma of the Breast</u> DUE TO (c) <u>1 yr</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Terminal pneumonia - 2 days.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>2 yrs 3 mo</u> <u>1 yr</u>
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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>May 19, 1956</u> <u>Aug 7, 1958</u> and last saw her alive on <u>Aug-6, 1958</u> Death occurred at <u>3:50 A.</u> m of the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In green or title) <u>Carl R. Ferris M.D.</u>		22b. ADDRESS <u>535 Argyle Bldg Kansas City, Missouri</u>	
22c. DATE SIGNED <u>8-8-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>AUG-9-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>		24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>	
25. DATE RECD. BY LOCAL REG. <u>8-9-58</u>		26. REGISTRAR'S SIGNATURE <u>neva minshall</u>	

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Social, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Harold B. Catterna*

Licensed Embalmer No. *3035*  
P. O. Address *H. C. Catterna*

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.