RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030453
STATE FILE NUMBER

FILED VS AUG 18 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 7319

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 40 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 7626 Reilly Avenue
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 7626 Reilly Avenue
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Herman; Middle: ; Last: Hansen
4. DATE OF DEATH: Month August; Day 4; Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 6/10/1871
9. AGE (last birthday): 88
IF UNDER 1 YEAR: Months ; Days
IF UNDER 24 HR: Hours ; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (City and state or country): Herman, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Carl Hansen
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Elizabeth Becker Hansen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Elizabeth Hansen
Address: 7626 Reilly St. Louis, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Senility
DUE TO (c): 422.2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1954, to August 4, 1959 and last saw him alive on July 20, 1959
Death occurred at 12:10 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. Benjamin (Degree or title) M.D.
22b. ADDRESS: 7430 Virginia Ave
22c. DATE SIGNED: 8/5/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Aug. 7, 1959
23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery
23d. LOCATION (City, town, or county) (State): Lemay, Missouri

24. FUNERAL DIRECTOR: C. Hoffmeister Mortuary
ADDRESS: 7814 So. Broadway St. Louis, Mo.
25. DATE RECD. BY LOCAL REG.: AUG 6 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Louis C. Hoffm

Licensed Embalmer No. 3821

P. O. Address 7814 S. Br

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