

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 8 2 9

FILED VS JAN - 4 1960

115-116

Registration District No. Primary Registration District No. 3020

Registrar's No. 285

STATE FILE NUMBER

UNRECORDED

| | | | | | | | |
|--|--|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Franklin | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Franklin | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington | | Length of stay in 1b 30 minutes | | c. CITY OR TOWN St. Clair | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hosp. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First John Middle B. Last Hanneken | | | 4. DATE OF DEATH Month Dec. Day 26, Year 1959 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Nov 30, 1890 | 9. AGE (last birthday) 69 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (City and state or country) Villa Ridge, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME Ben Hanneken | | | 13b. MOTHER'S MAIDEN NAME Christine Vondra | | | 14. NAME OF HUSBAND OR WIFE Lydia Hanneken | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 494 42 6313 | | 17. INFORMANT Address Lydia Hanneken St. Clair, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull with concussion and laceration DUE TO (b) of brain DUE TO (c) 30 min 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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.) Subject was struck by | | | | | |
| 20c. TIME OF INJURY 1:00 | Hour am. | Month, Day, Year 12/26/59 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 20e. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) Highway 30 at St. Clair Franklin Mo. |
| 20f. CITY, TOWN, OR LOCATION St. Clair | COUNTY Franklin | STATE Mo. | | | | | |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at DEAD ON ARRIVAL m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | | (Degree of title) | | 22b. ADDRESS Lawrence Union Mo | | 22c. DATE SIGNED 12/26/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Dec. 30, 1959 | 23c. NAME OF CEMETERY OR CREMATORY St. Clare Cemetery | | 23d. LOCATION (City, town, or county) St. Clair, Mo. | | (State) |
| 24. FUNERAL DIRECTOR Casey Lenox | | | ADDRESS St. Clair, Mo. | | 25. DATE RECD. BY LOCAL REG. 12/30/59 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

DOCUMENT

MEDICAL CERTIFICATION

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *R. M. Lerrot*

Licensed Embalmer No. 3601

P.O. Address *St. Clair, Mich.*

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.