

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002313

FILED VS JAN 12 1960

Registration District No. 172 Primary Registration District No. 3034 Registrar's No. 3

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Higginsville</b>			Length of stay in 1b <b>3 Mo. 15 Da.</b>		c. CITY OR TOWN <b>Higginsville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>1013 Walnut Higginsville</b>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1013 Walnut</b>	
3. NAME OF DECEASED (Type or print) First <b>Karen</b> Middle <b>Mary</b> Last <b>Larson</b>				4. DATE OF DEATH Month <b>I</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-8-1872</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>25</b>	IF UNDER 24 HR Hours <b></b> Mins. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Freaborn Co., Minn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Christian Hanson</b>			13b. MOTHER'S MAIDEN NAME <b>Ane Hanson</b>			14. NAME OF HUSBAND OR WIFE <b>Ole P. Larson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Verna I. Young</b> Address <b>Higginsville, Mo.</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>Acute cardiac decompensation &amp; pulmonary edema - 12</b> DUE TO (b) <b>Arterio sclerotic heart disease</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>Year</b>	
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 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></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>							
20d. INJURY OCCURRED WHILE AT WORK <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>January 1-1960</b> <b>January 2-1960</b> last saw her <b>live on January 1, 1960</b> Death occurred at <b>7:25</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>W. Kappasbrand, M.D.</b> (Degree or title)				22b. ADDRESS <b>Higginsville, Mo</b>		22c. DATE SIGNED <b>Jan. 2-1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>I-3-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arboret Lee</b>		23d. LOCATION (City, town, or county) <b>Albert Lee Minnesota.</b>		(State)
24. FUNERAL DIRECTOR <b>Forrest A. Hofer</b> ADDRESS <b>Higginsville, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Jan 3<sup>rd</sup> 1960</b>		26. REGISTRAR'S SIGNATURE <b>Lutie Gordon Jordan</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

FEB 3 1960

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 Forrest R. Hofer

Licensed Embalmer No. 480I

P. O. Address Higginsville, M

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