RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 3 1960

60-009180
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 671

1. PLACE OF DEATH a. COUNTY: St. Louis b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clayton — Length of stay in 1b: DOA c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis County Hosp — Inside Limits Yes ☑ No ☐	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo. b. COUNTY: St. Louis c. CITY OR TOWN: Webster Groves — Inside Limits Yes ☑ No ☐ d. STREET ADDRESS (If outside, give location): 534 Foote Ave. — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First NORMAN Middle E. Last HANSEN
4. DATE OF DEATH: Month Feb. Day 27 Year 1960

5. SEX	6. COLOR OR RACE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HR: Hours	Min.
M	W		3-15-12	47				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Insurance Manager	Insurance	Cromwell, Conn.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Andrew Hansen	Olive Perkins	Jacqueline Hansen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	010-10-1712	Walter W. Smith, 6235 Waterman

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) Metastatic Ca Oesphagus & Mediastinum
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of lung
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Cardiac Decompensation

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 Sept 8 1958, to 2/27/60 and last saw ~~her~~ him alive on 2/26/60
Death occurred at St Louis County Hosp m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Romueller MD	4161 Lindell Blvd	3/29/60

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Cremation	2-29-60	Missouri Crematory	St. Louis, Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Parker-Aldrich,	Webster Groves	2-29-60	John C. Murphy 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_____ Signed Lalie Walch

Signature of Student Embalmer

Licensed Embalmer No. 4 39

P. O. Address Webster Gro

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.