

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 12 1960

60-011354

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 194

UNDECEASED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON	a. STATE MISSOURI	b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) INDEPENDENCE	Length of stay in 1b 5 DAYS	c. CITY OR TOWN GRANDVIEW	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SANITARIUM	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS GRANDVIEW (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First JAMES	Middle J.	Last HANSEN	Month APRIL	Day I	Year 1960	

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 4--15--1888	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	11. BIRTHPLACE (City and state or country) NEAR COUNCIL BLUFF IOWA	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME JACOB HANSEN	13b. MOTHER'S MAIDEN NAME KATE ANDERSON	14. NAME OF HUSBAND OR WIFE BERTHA HANSEN
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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. none	17. INFORMANT MRS A.D. M^c CORMICK	Address INDEPENDENCE MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	Years
	Chr Cor Pulmonale	
	DUE TO (c)	Years
	Chr Pulmonary Emphysema	

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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 INDEPENDENCE MO	COUNTY INDEPENDENCE MO	STATE
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21. I attended the deceased from Mar 19, 1960 to Apr. 1, 1960 and last saw him alive on Mar. 31, 1960
Death occurred at 8:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Drs. Grasseke & Link (Degree or title) Grasseke, M.D.	22b. ADDRESS 10901 Winner, Independence, Mo.	22c. DATE SIGNED 4-1-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE April 4-1960	23c. NAME OF CEMETERY OR CREMATORY MOUND GROVE	23d. LOCATION (City, town, or county) (State) INDEPENDENCE MO
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24. FUNERAL DIRECTOR ROLAND R. SPEAKS	ADDRESS INDEPENDENCE MO.	25. DATE RECD. BY LOCAL REG. 4-4-60	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 30 1960

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

Rollie Kessel

Licensed Embalmer No. 4690

P. O. Address Andover, Mass.

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.