

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021008

FILED VS. MAY 25 1960

318

Primary Registration District No. 1003

Registrar's No. 5032

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>				Length of stay in 1b <b>45 YEARS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3728 WISCONSIN</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET R. HANSEN</b>				4. DATE OF DEATH Month Day Year <b>MAY 11 1960</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</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>2/20/1891</b>		
9. AGE (last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR				
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>AT HOME</b>		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>FRANK DOLSON</b>			13b. MOTHER'S MAIDEN NAME <b>KATHERINE BECKER</b>			14. NAME OF HUSBAND OR WIFE <b>WALTER C. HANSEN</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>YES</b>		17. INFORMANT <b>WALTER C. HANSEN, 3728 WISCONSIN</b>		Address <b>ST. LOUIS</b>	
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) <b>Cerebrovascular accident</b>							<b>24 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis, generalized</b>							<b>? years</b>	
DUE TO (c) <b>331x</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>EMPHYSEMA OBSTRUCTIVE WITH COR PULMONALE</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 a.m. p.m. Month, Day, Year								
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>APR. 7, 1951</b> to <b>MAY 11, 1960</b> and last saw her/him alive on <b>MAY 10, 1960</b> Death occurred at <b>7:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Herbert Sweet MD</b>				22b. ADDRESS <b>508 N Grand</b>			22c. DATE SIGNED <b>5-11-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/14/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>			
24. FUNERAL DIRECTOR <b>HOFFMEISTER COLONIAL MORTUARY</b> <b>6464 CHIPPEWA STREET, ST. LOUIS, MO</b>				25. DATE RECD. BY LOCAL REG. <b>MAY 12 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b> <b>MDG</b>		

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Geo. C. Brannon

Licensed Embalmer No. 4767

P. O. Address St Louis

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.