

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021925

INDEXED

FILED VS JUN 6 1960

317

Primary Registration District No. 500

Registrar's No. 1556

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch, Mo.		Length of stay in 1b 429 days		c. CITY OR TOWN St. Louis (11)		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 728 Wilmington Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Judson Middle E Last Hanson				4. DATE OF DEATH Month 5-12 Day 1960 Year															
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 7-14-04		9. AGE (last birthday) 55 yrs		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) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Internatiol Box		11. BIRTHPLACE (City and state or country) Steelville Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.												
13a. FATHER'S NAME Edward Hanson				13b. MOTHER'S MAIDEN NAME Lizzie Staples				14. NAME OF HUSBAND OR WIFE Magdalen Hanson											
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 Address 497-05-8573 Robt. Koch Hosp. Record, Koch Mo.														
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) Metastatic Carcinoma of the Liver										1 1/2 Yrs?									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) Carcinoma of the descending colon									
DUE TO (c)										JAN 1959									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Tuberculosis							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 Month, Day, Year e.m. p.m.		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 3-20-59 to 5-12-60 and last saw him him alive on 5-12-60 Death occurred at 7:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) Frank Cohen M.D.						22b. ADDRESS Robt. Koch Hosp., Koch, Mo.				22c. DATE SIGNED 5-12-60									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/14/60		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				23d. LOCATION (City, town, or county) (State) St. Louis Mo.											
24. FUNERAL DIRECTOR Fendler Und. Co. 7420 Michigan Ave.				ADDRESS (11)		25. DATE RECD. BY LOCAL REG. 5-13-60		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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Mic

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.