

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60=022601

STATE FILE NUMBER

FILED VS JUN 16 1960

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 57

DEED

1. PLACE OF DEATH a. COUNTY Clay			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs		Length of stay in 1b 11 yrs	c. CITY OR TOWN Excelsior Springs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1010 Magnolia West		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1010 Magnolia West		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Selmer Middle H. Last Hanson			4. DATE OF DEATH Month May Day 18, 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 10-26-1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Osteopath		10b. KIND OF BUSINESS OR INDUSTRY Physician	11. BIRTHPLACE (City and state or country) Canton, S. Dakota		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Gustav Hanson		13b. MOTHER'S MAIDEN NAME Margit Anderson		14. NAME OF HUSBAND OR WIFE Maxine Hanson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If WW I war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 490-10-7890		17. INFORMANT Maxine Hanson, 1010 Magnolia West, Excelsior Springs, 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 sev, weeks
IMMEDIATE CAUSE (a) Cerebral hemorrhage					years
DUE TO (b) Hypertension					years
DUE TO (c) Arteriosclerosis					years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Previous Cerebral hemorrhage - 6 years ago					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 <input type="checkbox"/> 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 4/22/60 to 5/18/60 and last saw her/him alive on 5/18/60 Death occurred at 11:15 A. M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Selmer H. Hanson MD</i> (Degree or title)			22b. ADDRESS M. D. Excelsior Springs, Mo.		22c. DATE SIGNED 5/24/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-21-60	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Memorial Gardens, Chillicothe, Mo.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR Prichard Funeral Home, Inc.			25. DATE RECD. BY LOCAL REG. 6-16-60		26. REGISTRAR'S SIGNATURE <i>Huntard Wike m.</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS JUN 16 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 Louise Jarman

Licensed Embalmer No. 458

P. O. Address Enclis, Fla

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.