

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010073

STATE FILE NUMBER

AMENDED

Registration District No. 276 Primary Registration District No. 4410 Registrar's No. 12

FILED MAR 20 1961

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Phelps</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. James</u>		c. CITY OR TOWN <u>ST. James</u>	
Length of stay in 1b <u>4 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Soldiers Home Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>✓</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Hansel</u>			4. DATE OF DEATH Month Day Year <u>March 14th 1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-1880</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (City and state or country) <u>NEBRASKA</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Do NOT Know</u>		13b. MOTHER'S MAIDEN NAME <u>Do NOT Know</u>	14. NAME OF HUSBAND OR WIFE <u>George R. Hansel</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT Address <u>Soldiers Home office - ST. James, MO</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Neuronothage</u> DUE TO (b) <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
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. 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 <u>March 14</u> to <u>March 14</u> and last saw <u>her</u> <u>live</u> on <u>March 14-1961</u> Death occurred at <u>12-05</u> <u>PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joe. A. Grass</u>		22b. ADDRESS <u>112 St. James - Mo -</u>	22c. DATE SIGNED <u>3-14-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-17-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Pr. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Rock Island, Ill.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Oral E. Licklider - St. James, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-14-1961</u>	26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u>	

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Oree E. LeKlier

Licensed Embalmer No. 354

P. O. Address St James

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.