

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-034405
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8609

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3003 WISCONSIN</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3003 WISCONSIN</u>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle Last <u>HANSON</u>			4. DATE OF DEATH Month <u>SEPT.</u> Day <u>14</u> Year <u>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>Nov. 10 1879</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>OLD MINES Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOSEPH BOYER</u>		13b. MOTHER'S MAIDEN NAME <u>ROSENA COLEMAN</u>		14. NAME OF HUSBAND OR WIFE <u>FRANK HANSON</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.	17. INFORMANT <u>LORETTA SPARK 3003 WISCONSIN</u>		

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) <u>MEDULLARY PARALYSIS</u>		
DUE TO (b) <u>CEREBRO VASCULAR ACCIDENT</u>		
DUE TO (c) <u>331X</u>		

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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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
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21. I attended the deceased from <u>8-20-61</u> to <u>9-13-61</u> and last saw her/him alive on <u>9-13-61</u> Death occurred at <u>910a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>W. Scott Brestler D.O.</u>	22b. ADDRESS <u>1824 So 18th St</u>	22c. DATE SIGNED <u>9-15-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>SEPT. 18 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>DESOTO Mo</u>
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24. FUNERAL DIRECTOR <u>Thomas Kutas 2906 Grandis</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 15 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2 to 3
5 to 7
Friday

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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Brown

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.