

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046374

FILED JAN 5 1962

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12219

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

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 St. Louis		c. CITY OR TOWN Madison	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If outside, give location) 233 W. Airline Dr.	
3. NAME OF DECEASED (Type or print) Lorentz Clark Hanson			4. DATE OF DEATH Month Day Year Dec. 27, 1961
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 1/23/20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Shell Oil Co.	11. BIRTHPLACE (City and state or country) Omaha, Neb.
13a. FATHER'S NAME Lorentz Hanson		13b. MOTHER'S MAIDEN NAME Nina Clark	14. NAME OF HUSBAND OR WIFE Donna Hanson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. Donna Hanson
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) Congestive Heart Failure			2 weeks
DUE TO (b) Anaplastic Carcinoma in the abdomen (Primary site unknown)			3 years
DUE TO (c) 199.2			
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 s.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 December 12, 1961, to December 27, 1961 and last saw her alive on December 27, 1961 Death occurred at 10:25 p/m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. O. Vermillion</i> C. O. Vermillion, M. D.		22b. ADDRESS Barnes Hospital	22c. DATE SIGNED 12/28/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1961 Dec. 28	23c. NAME OF CEMETERY OR CREMATORY Valley View	23d. LOCAL REGISTRY (City and State) Edwardsville, Ill
24. FUNERAL DIRECTOR Weber Funeral Home, Edwardsville, Ill.		25. DATE RECD. BY LOCAL REG. DEC 28 1961	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

FEB 15 1962

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 Philip H Weber

Licensed Embalmer No. 4985

P. O. Address Edwardsville

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.