

FILED APR 7 1944
749

State File No. _____
Registrar's No. 1302

Registration District No. _____

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Mercy Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether _____)

In this community 1 day
years, months or days

3. (a) PRINT FULL NAME RONALD F. HANGER

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex MALE

5. Color or race W

6. (a) Single, widowed, married, divorced. CHILD

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 12 - 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 39 If less than one day _____ hr. _____ min.

9. Birthplace Windsor Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

MOTHER FATHER

12. Name Wm Hanger

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Helen Montoya

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mercy Hosp Record

(b) Address R. C. Mo.

17. (a) removal
(Burial, cremation, or removal)

(b) Date thereof 3-23-44
(Month) (Day) (Year)

(c) Place: burial or cremation Windsor Mo

18. (a) Signature of funeral director John E. Brown

(b) Address Mo

19. (a) 3-23-44 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Windsor Mo
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? Child (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22nd
year 1944 hour 7:55 PM 7:55 Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him as a Deputy Coroner, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction
Fecal Impaction

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy See Above

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of Injury _____

23. Signature A. E. Usher (M. D. or other) M.D.
Address 23 M Coy Date signed 3/23/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

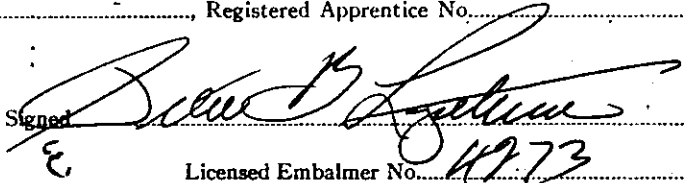
1800

1800

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed 

Licensed Embalmer No. 11773

P. O. Address KC

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 this body is not embalmed, fact should be so stated above.