

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **26**

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER
0009540

VS 300
Rev. 4/59

1 **0090**

2 **0090**

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12 **90**

13 **1-0**

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY BOLLINGER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY BOLLINGER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARBLE HILL		c. CITY OR TOWN MARBLE HILL	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If outside, give location) Rt 1	
3. NAME OF DECEASED (Type or print) John FRANKLIN HANSEN		4. DATE OF DEATH Month MARCH Day 15 Year 1965	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct 26 1978
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM		10b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. FATHER'S NAME John FRANKLIN HANSEN		13b. MOTHER'S MAIDEN NAME AMELIA NORDMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) pyelonephritis DUE TO (c) _____		17. INFORMANT Mrs. Zada Hansen, Marble Hill	
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 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. _____ 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 _____	
21. I attended the deceased from 2/15/63 to 1/5/65 and last saw him alive on 1/5/65 Death occurred at 5:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Armed M. Hoxworth		22b. ADDRESS M.D. 210 Christine Cape Gir. Mo.	
22c. DATE SIGNED 3/18/65		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3-17-65	23c. NAME OF CEMETERY OR CREMATORY BOLLINGER Co. mem.	23d. LOCATION (City, town, or county) (State) Lutesville MO
24. FUNERAL DIRECTOR Gene Hays		25. DATE RECD. BY LOCAL REG. 3/23/65	
26. REGISTRAR'S SIGNATURE Mrs. Buford Crader			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

MAR 30 1965

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

Licensed Embalmer No. 5086

P. O. Address

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.