

REC'D FEB 21 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1605

Do not use this space.

1. PLACE OF DEATH  
(a) County Buchanan Registration District No. 85  
(b) Township ..... Primary Registration District No. 100 Registered No. 3  
(c) City St. Joseph, (d) Street No. 1104 North 18th. St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 38 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Susanna Werner Kucks  
(a) Residence, No. 1104 North 18th. St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed,</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Charles R. Kucks,</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan'y 5, 1860</u>		
7. AGE	YEARS <u>78</u>	MONTHS <u>11</u>
	DAYS <u>26</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>At Home,</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year).....	11. Total time (years) spent in this occupation.....
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Doniphan, Kansas,</u>		
FATHER	13. NAME <u>Nicholas Werner,</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown, Germany,</u>	
MOTHER	15. MAIDEN NAME <u>Mary Schlitzbaum</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown, Germany,</u>	
17. INFORMANT <u>Mrs. Chas. A. Floyd</u> (ADDRESS) <u>1121 Powell Street,</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Doniphan, Ks.</u> DATE <u>Jan'y 3rd, 39</u>		
19. FUNERAL DIRECTOR (NAME) <u>Heaton Behold Beama</u> (ADDRESS) <u>319 So. 10th Str. Linn Co. Mo.</u>		
20. FILED <u>Jan. 3, 1939</u> <u>J. Nestlebeck</u> ET Local Registrar.		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan'y 1st, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1939, to Jan 1, 1939.  
I last saw h. u alive on Jan 1, 1939. Death is said to have occurred on the date stated above, at 10:30 p.m.  
The principal cause of death and related causes of importance were as follows:  
Pneumonia

Date of onset Jan 1-39

Other contributory causes of importance:  
Senile  
art. scler. heart  
Heart Dis. Arterio-sclerotic

Name of operation ..... Date of .....  
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify .....  
(Signed) L. N. Johnson, M. D.  
(Address) St. Joseph, Mo.

9562

**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, Jan. 1st 19

or by

Registered Apprentice No. , working under my personal supervision.

Signed W. E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So 10th St. Joseph

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

1605  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Buchanan Registration District No. 85-  
 (b) Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. \_\_\_\_\_  
 (c) City St Joseph (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Susanna Werner Kuehn  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hr. or _____ min.
	<u>78</u>	<u>11</u>	<u>26</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER  
 13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER  
 15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_  
 18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_  
 19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_  
 20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 1, 1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
Pneumonia  
Bronchial  
9513

Other contributory causes of importance:  
arterialemia  
Heart Dis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) L. H. Fuson, M. D.  
 (Address) St Joseph, Mo.

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Exact statement of OCCURRENCE is very important.

