

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40150

Registration District No. 496

Primary Registration District No. 3025

State File No. \_\_\_\_\_

Registrar's No. 108

1. PLACE OF DEATH:

(a) County Lin  
 (b) City or town Brookfield  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: McJannet  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 days  
 (Specify whether  
 In this community All 7 days  
 years, months or days)

8. (a) PRINT FULL NAME WILLIAM EDITH NUSSMAN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 4 1889  
 (Month) (Day) (Year)

8. AGE: Years 49 Months 11 Days 21 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Rockville (City, town, or county) (State or foreign country) S

10. Usual occupation Housekeeper

11. Industry or business \_\_\_\_\_

12. Name R. A. Stewart

18. Birthplace Polk County, Mo. (City, town, or county) (State or foreign country)

14. Maiden name Myrtle White

15. Birthplace Polk County, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. D. E. Yankee

(b) Address 806 E. Highland, Carthage, Mo.

17. (a) Burial (b) Date thereof Nov 27-1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keytravell

18. (a) Signature of funeral director W. J. Hancock

(b) Address Keytravell, Mo. 64505

19. (a) Nov 30 39 (b) W. J. Hancock  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Chariton  
 (c) City or town Rockville  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25  
 year 1939 hour 8 minute 20 P. M.

21. I hereby certify that I attended the deceased from Nov 1 1939, to Nov 25 1939;  
 that I last saw her alive on Nov 25 1939;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration 4 d

Due to Abscess Gall Bladder

Due to Shock 176 4 mo.

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations Gallbladder & Pancreas  
Gall Bladder  
 Of autopsy None

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) \_\_\_\_\_ 0  
 (b) Date of occurrence \_\_\_\_\_ 0  
 (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? \_\_\_\_\_ 0

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_ 0

23. Signature W. J. Hancock (M. D. or other) 1  
 Address Rockville, Mo. Date signed 11/27/39

RECEIVED  
District Health Officer No. 44,  
District \_\_\_\_\_  
Date \_\_\_\_\_  
DEC 6 1239-1456  
1939

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 \_\_\_\_\_  
H. D. Burnett, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed H. D. Burnett  
Licensed Embalmer No. 3046  
P. O. Address Keytown Mo.

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.

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

40156  
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 496  
(b) Township Brownfield Primary Registration District No. 8025 Registered No. ....  
(c) City Brownfield (d) Street No. .... 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lillian Edith Kussman

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Div

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 25 1939

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

22. I HEREBY CERTIFY, That I attended deceased from

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
49 11 21

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

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 .....

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rothville Mo.

Other contributory causes of importance:

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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.

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Feb 16 1940 Wm. H. ... Local Registrar.

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify .....  
(Signed) J. W. ..., M. D.  
(Address) Brownfield Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY THE BOARD OF HEALTH. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

