

240
39
23139

Registration District No. 637

Primary Registration District No. 4382

Registrar's No. 38

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

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Thayer

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2

In this community 45

years, months or days (Specify whether)

3. (a) PRINT FULL NAME Francis B. Susseny

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Sarah Ricketts

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

7. Birth date of deceased Aug 8 1852

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>88</u>	<u>1</u>	<u>16</u>	hr. min.

9. Birthplace Iowa

(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

12. Name Wm Susseny

13. Birthplace Iud.

(City, town, or county) (State or foreign country)

14. Maiden name Bealla Hayden

15. Birthplace Iowa

(City, town, or county) (State or foreign country)

16. (a) Informant Pam Susseny

(b) Address Winona - Mo.

17. (a) Burial (b) Date thereof 9-25-40

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clyfton Cem.

18. (a) Signature of funeral director Ray Carr

(b) Address Thayer - Mo

19. (a) Oct. 4 - 1940 (b) Lola E. Johnson

(Date received local registrar) (Registrar's signature) DEPUTY

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Oregon

(c) City or town Thayer

(If outside city or town limits, write "RURAL")

(d) Street No. 6

(If rural, give location)

(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24

year 1940 hour 7:00 minute AM

21. I hereby certify that I attended the deceased from Sept 23-40

to Sept 24 1940

that I last saw him alive on Sept 23-1940

and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia acute

Duration 4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

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?

563 (Specify type of place)

While at work? (a) Means of injury

23. Signature JL Barnes (M. D. or other)

Address Thayer Mo Date signed Oct 3-40

RECEIVED

District Health Officer No. 5,

District File Number 10401014

Date Filed _____

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.....

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