

No. 2  
4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21207

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

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 887

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

1. PLACE OF DEATH:

(a) County BUCHANAN

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

(c) Name of hospital or institution: STATE HOSPITAL No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 mo. 3 days  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town: Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 644 Park  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Arthur Cutting

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. 499-10-3668

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28  
year 1941 hour 8 minute 25 P. M.

21. I hereby certify that I attended the deceased from February 25, 1941, to June 28 1941;  
that I last saw him alive on June 28 1941;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife Mrs Effie Cutting

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased: January 17 1884  
(Month) (Day) (Year)

Immediate cause of death  
Hypostatic Pneumonia 6-25-41

8. AGE: Years 57 Months 5 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Hypertensive Cardiovascular Disease 12/1

Due to \_\_\_\_\_

9. Birthplace Winfield Kansas  
(City, town, or county) (State or foreign country)

Other conditions Cerebral Hemorrhage  
(Include pregnancy within 5 months of death)

Due to Arteriosclerosis

10. Usual occupation Stone mason

Major findings: no operation

Of operations \_\_\_\_\_

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

MOTHER FATHER { 12. Name Leander Cutting

13. Birthplace ? ? 9

14. Maiden name: Lourana Parkins

15. Birthplace ? ? 9

Of autopsy no autopsy

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

(a) Accident, suicide, or homicide (specify) none

(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)

(e) Means of injury \_\_\_\_\_

16. (a) Informant Mrs Effie Cutting

(b) Address 644 Park, K.C., Mo.

17. (a) Removal (b) Date thereof 7-2-41  
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cem. Independence, Mo.

23. Signature D. F. Johnson (M. D. or other) Dr.

Address State Hosp # 2 Date signed 6-28-41

18. (a) Signature of funeral director Sheil Hamilton

(b) Address 6606 Andy Ave.

19. (a) 6/29/41 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

St. Joseph, Mo

JUL 9 1941

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**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.**