17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6058

State File No. .....

FILED FEB 15 1943

Registration District No. 69 Primary Registration District No. 4107 Registrar's No. 2

1. PLACE OF DEATH
(a) County Cedar
(b) City or town El Dorado Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Adult Conservation Club
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Sixteen days (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cedar
(c) City or town El Dorado Spg Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 114 Mt Boulevard
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Fisher E Kuder
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Fannie Kuder
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Aug (Month) 30 (Day) 1866 (Year)
8. AGE: Years 77 Months 7 Days 9 If less than one day ..... hr. ..... min.
9. Birthplace ..... (City, town, or county) O (State or foreign country)
10. Usual occupation Farmer
11. Industry or business .....
FATHER 12. Name .....
FATHER 13. Birthplace ..... (City, town, or county) O (State or foreign country)
MOTHER 14. Maiden name .....
MOTHER 15. Birthplace ..... (City, town, or county) O (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) 1-23-43 (Date received local registrar) (b) L T Dunaway (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22 year 1943 hour 11 minute 45 A.M.
21. I hereby certify that I attended the deceased from Jan 14, 1943 to Jan 22, 1943 that I last saw him alive on Jan 19, 19..... and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma	
~~Carcinoma~~ Rectum & Sig Mesed	
Due to Pleurisy	
Due to	
Other conditions (Include pregnancy within 3 months of death) H6	
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature L T Dunaway M.D. or other)
Address El Dorado Sp Date signed 1-23-43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 1-43-145
Date Filed 2-10-43

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 wit the above constitutes grounds for revocation of license.)

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

. S. No. 2B
OM —8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6058

Registration District No. 61 Primary Registration District No. 4107 Registrar's No.

1. PLACE OF DEATH:

(a) County Cedar

(b) City or town El Dorado Springs
(If outside city or town limits, write "RURAL" and name of township)

(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 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Fisher E Kuder

3. (b) If veteran, name war

3. (c) Social Security No. no

4. Sex M

5. Color or race (white)

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

6. (b) Name of husband or wife Fannie Kuder

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

7. Birth date of deceased Aug (Month) 30 (Day) 1866 (Year)

8. AGE: Years 77 Months 2 Days If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
12. Name unknown
13. Birthplace Mo (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace Mo (City, town, or county) ~~Jan 25 43~~ (State or foreign country)

16. (a) Informant J Lucky
(b) Address Wheatland

17. (a) ~~Bur Fair View~~ (Burial, cremation, or removal) (b) Date thereof Jan 26-43 (Month) (Day) (Year)

(c) Place: burial or cremation Fair View
Hickory Co. Jr Lucky

18. (a) Signature of funeral director
(b) Address Wheatland Mo

19. (a) 2/16/43 (Date received local registrar) (b) L T Dunaway (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 ; that I last saw h alive on 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY