

FILED FEB 10 1947

Registration District No. 360

Primary Registration District No. 207-6 6225

1. PLACE OF DEATH

(a) County Kernon
(b) City or town Harrodsburg, Wash
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 3 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. 17 days
In this community One month & 17 days
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. 3522 Combes
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

Laura Hutseep

3. (b) If veteran, name war no

3. (c) Social Security No. ?

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Clarence Hutseep

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

7. Birth date of deceased 7 (Month)

22 (Day) 1898 (Year)

8. AGE:

Years 49

Months 6

Days 6

If less than one day hr. _____ min. _____

9. Birthplace

Texas Co Mo
(City, town, or county)

(State or foreign country) (1)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name

James Crostree

13. Birthplace

Tennessee

14. Maiden name

Brenda Brant

15. Birthplace

Tennessee

16. (a) Informant

Records

(b) Address

State Hospital # 3

17. (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

Jan 29 1947
(Month) (Day) (Year)

(c) Place: burial or cremation

Rockport Mo

18. (a) Signature of funeral director

Raymond Service

(b) Address

Nevada Mo.

19. (a)

1-29-47
(Date received local registrar)

(b)

Raymond Service
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28
year 1947 hour 10:10 minute 7 M.

21. I hereby certify that I attended the deceased from 12-11-1946 to 1-28-47
that I last saw him alive on 1-28-47
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis D.K.
Due to Chronic Valvular Heart Disease 37 years

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. Burch (M. D. or other) _____
Address State Hospital # 3 Date signed 1-28-47

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

CR-2
RE-1

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 Allen V. Kays

Licensed Embalmer No. 1968

P. O. Address Nevada 9M

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.