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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12855

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

Registration District No. 73

Primary Registration District No. 5290

Registrar's No. 32

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Kearney Rural  
(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 Mo (b) County Clay 24

(c) City or town Kearney Rural 0  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location) 0

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Cuthbertson

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

3. (c) Social Security No. 712

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5  
year 1947 hour 5 minute 30 P.M.

4. Sex Female 5. Color or race white

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

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

7. Birth date of deceased Oct 12 1862  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1946, to April 5 1947  
that I last saw her alive on April 3 1947  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>5</u>	<u>24</u>	hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage 4 days.

Due to Arteriosclerosis 20 yrs.

Due to Hypertension 10 yrs.

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

10. Usual occupation Was a House wife

11. Industry or business Taking care of the Home

12. Name Burch

13. Birthplace Ga  
(City, town, or county) (State or foreign country)

14. Maiden name Taylor

15. Birthplace Ga  
(City, town, or county) (State or foreign country)

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

Major findings: § 2 P

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Nellie Daniels

(b) Address Kearney Mo

17. (a) Burial (b) Date thereof 4-7-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview

18. (a) Signature of funeral director Leonard Fry

(b) Address Kearney Mo

19. (a) April 8, 1947 (b) Thomas Haynes  
(Date received local registrar) (Registrar's signature)

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 M. P. Schuhmacher (M. D. or other) M.D.

Address Liberty Mo Date signed 4-8-47

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

MAY 1 1947

MAY 1 1947

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

*Leonard Fry*

Licensed Embalmer No.

*1677*

P. O. Address

*Kearney 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, fact should be so stated above.