No. 2
-1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 4 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

33566
State File No.

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 291

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Anna Stell Memorial Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 1/2 mo (Specify whether years, months or days)
In this community 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 410 - S - Main
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME IDA BELLE Husted
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Chas. Husted
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 11 (Day) 1873 (Year)

8. AGE: Years 74 Months 8 Days 14 If less than one day hr. min.

9. Birthplace Adair Co (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housekeeper
11. Industry or business
MOTHER FATHER
12. Name Jacob R. Cook
13. Birthplace Indiana (City, town, or county) (State or foreign country)
14. Maiden name Catherine Rider
15. Birthplace Penna. (City, town, or county) (State or foreign country)
16. (a) Informant Julia Cross
(b) Address 710 N. Davis Kirksville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-47 (Month) (Day) (Year)
(c) Place: burial or cremation Maple Hill - Kirksville
18. (a) Signature of funeral director Summers & Powell
(b) Address Kirksville Mo
19. (a) 10-27-47 (Date received local registrar) (b) Nate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25 year 1947 hour 2 minute 07 P. M.
21. I hereby certify that I attended the deceased from July 6 1947, 19..., to Oct 25, 1947, that I last saw h. alive on Oct 25, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Anoxia	24 hrs
Due to: Malignancy of lung	months
Due to: Malignancy of left femur	"
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
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? 2
While at work? (Specify type of place) (e) Means of injury

23. Signature M. T. Gutenschn (M. D. or other) MD
Address Kirksville, Mo. Date signed 10-25-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No
District File Number 11-47-
NOV - 3 1947
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 James J. Taylor, Registered Apprentice No. 436, working under my personal supervision.

Signed Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Trenton, 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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 291

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kirksville
(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 Ida Belle Husted

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 11 (Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 25
year 1947 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.

Immediate cause of death

Due to primary Left Femur

Due to metastasis to Lung

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 55B

Of autopsy

Duration

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 M. T. Gutensohn (M. D. or other) D.O.
Address Kirksville, Mo Date signed 11-18-47

SUPPLEMENTARY

33 5466