

FILED AUG 2 1948

State File No. ....

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 800

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:  
**Missouri Methodist Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **ten minutes**  
(Specify whether years, months or days) **10 minutes**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Doniphan 997**

(c) City or town **Denton 14**  
(If outside city or town limits, write "RURAL")

(d) Street No. **Denton 2**  
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No) **2**  
If yes, name country

3. (a) PRINT FULL NAME **George Husted**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **Male 0** 5. Color or race **White**

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

6. (b) Name of husband or wife **Sarah Husted**

6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **Mar 20, 1869**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>79</b>	<b>3</b>	<b>19</b>	hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER

12. Name **Marcus Husted**

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

14. Maiden name **unknown**

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

16. (a) Informant **Sarah Husted**

(b) Address **Denton, Kansas.**

17. (a) **Removal** (Burial, cremation, or removal)

(b) Date thereof **7/9/48**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Bellview Leona Kans.**

18. (a) Signature of funeral director **E. K. Karr**

(b) Address **Troy, Kansas**

19. (a) **7-30-48** (Date received local registrar)

(b) **H. B. Jenkins** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **9**  
year **48** hour **3:50** minute **P** M.

21. I hereby certify that I attended the deceased from **7-9-48** to **7-9-48**, 19**48**  
that I last saw him alive on **7-9-48**, 19**48**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **1 Day**

Due to **arteriosclerosis** **15 years**

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: **82**  
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?  
**11**

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

23. Signature **J. P. ...** (M. D. or other) **MD**  
Address **420 N. 82 St. ...** Date signed **7/9/48**

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

AUG 5 1948

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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..... *E. L. Kan*

Licensed Embalmer No. *2532*

P. O. Address..... *Troy Kan*

**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.**