

FILED MAY 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11699

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 156

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

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>	c. LENGTH OF STAY (in this place) <u>8 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>	<u>14</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Seminole Apartments</u>		d. STREET ADDRESS (If rural, give location) <u>East Tenth</u>	<u>0</u>

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARY</u>	b. (Middle) <u>ETTA</u>	c. (Last) <u>KUHNE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 7 1949</u>
-------------------------------------	------------------------	-------------------------	------------------------	---

5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 16, 1870</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>21</u>	IF UNDER 4 HRS. Hours <u>0</u> Min. <u>0</u>
----------------------	-------------------------------	---	---------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZENSHIP OF WHAT COUNTRY? <u>U. S. A.</u>
--	--	---	--

13a. FATHER'S NAME <u>John Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Lucinda Garrett</u>	14. NAME OF HUSBAND OR WIFE <u>E. J. Kuhne</u>
--------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>D. K.</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. C. E. Blattner</u>	ADDRESS <u>Fulton, Mo.</u>
---	---	--	----------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 1/2 yrs</u> <u>4222</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial Degeneration</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from Apr 47, 1949 to May 6, 1949, that I last saw the deceased alive on May 6, 1949, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John J. Brown M.D.</u>	23b. ADDRESS <u>Fulton, Mo.</u>	23c. DATE SIGNED <u>5-7-49</u>
--	---------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>May 8, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wellsville</u>	24d. LOCATION (City, town, or county) (State) <u>Wellsville, Mo.</u>
--	------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>May 7-1949</u>	REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>	426	25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Mearns</u>	ADDRESS <u>Fulton, Mo.</u>
--	---	-----	---	----------------------------

Date Filed MAY 11 1949
District File Number
District Health Officer No. 9,

RECEIVED

JUL 20 1949

JUN 27 1949

MAY 13 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Walter J. Harris, Jr.

Signed _____
Student Embalmer

Licensed Embalmer No. 4357

P. O. Address Fulton, 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.