

FILED OCT 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30841

State File No.

No. 300
10.48

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

BIRTH NO.		REG. DIST. NO. <u>164</u>		PRIMARY REG. DIST. NO. <u>3022</u>		Registrar's No. <u>109</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Johnson</u>		b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Warrensburg</u>)		a. STATE <u>Missouri</u>		b. COUNTY <u>Henry</u>	
c. LENGTH OF STAY (In this place) <u>6 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Big Creek</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Warrensburg Hospital & Clinic Inc.</u>				d. STREET ADDRESS (If rural, give location) <u>1 1/2 Miles North of Norris Mo.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Henrietta</u>		b. (Middle)		c. (Last) <u>Hussey</u>	
4. DATE OF DEATH		(Month) <u>Sept</u>		(Day) <u>25</u>		(Year) <u>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>Nov. 30 1868</u>	
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></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		11. BIRTHPLACE (State or foreign country) <u>East Linn Cass Co. Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13a. FATHER'S NAME <u>Alexander Hinote</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Kennedy</u>	
14. NAME OF HUSBAND OR WIFE <u>R. D. Hussey (Deceased)</u>				15. WAS DECEASED EVER IN U.S.-ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Lewis Hussey</u>				ADDRESS <u>Rt. #1 Blairstown, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal hypertensive pneumonia</u>		ANTECEDENT CAUSES					
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture right hip</u>					
		DUE TO (c) <u>Diabetes mellitus</u>					
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) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>Blairstown</u> (COUNTY) <u>Henry</u> (STATE) <u>Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9-19-49</u> a.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Went to night store - caught toe in door and fell</u>			
22. I hereby certify that I attended the deceased from <u>Sept 19, 1949</u> , to <u>Sept 25, 1949</u> , that I last saw the deceased alive on <u>Sept 20, 1949</u> , and that death occurred at <u>2:15 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title)				23b. ADDRESS <u>Warrensburg Mo.</u>		23c. DATE SIGNED <u>9-25-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 28-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>W. L. Adams Community Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Johnson Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 25, 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Blairstown Mo.</u>	

RECEIVED
OCT 3 1949
JOHNSON COUNTY HEALTH DEPT.

Wm. H. Mason
Emb. 11/11/49

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *Paul W. Williams Jr.*

Licensed Embalmer No. 4510

P. O. Address *Clinton, 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.