

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41328**

FILED DEC 1 1952

BIRTH NO. _____ REG. DIST. NO. **352** PRIMARY REG. DIST. NO. **4517** Registrar's No. **101**

1. PLACE OF DEATH a. COUNTY Taney		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Taney	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Forsyth	c. LENGTH OF STAY (in this place) 275 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Forsyth	
d. FULL NAME OF HOSPITAL OR INSTITUTION Skags Community Hosp		d. STREET ADDRESS (If rural, give location) Forsyth	

3. NAME OF DECEASED (Type or Print) Watson Emerson Shusher	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Nov. 16, 1952
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5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH JAN. 30, 1880	9. AGE (In years last birthday) 72	if UNDER 1 YEAR Months 9 Days 16	if UNDER 24 Hrs. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Levi Shusher	13b. MOTHER'S MAIDEN NAME Elizabeth Smuck	14. NAME OF HUSBAND OR WIFE Elizabeth Shusher
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Roy Shusher ADDRESS Forsyth Mo
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 days 2 yrs 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Deberat thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. B. Pneumonia			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 332 X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov 11, 1952**, to **Nov 16, 1952**, that I last saw the deceased alive on **Nov 15, 1952**, and that death occurred at **1 A** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)	23b. ADDRESS Forsyth, Mo	23c. DATE SIGNED 11/16/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/18/1952	24c. NAME OF CEMETERY OR CREMATORY Bank Memorial Park	24d. LOCATION (City, town, or county) (State) Bronson Mo
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DATE REC'D BY LOCAL REG. 11-28-52	REGISTRAR'S SIGNATURE S E Cogswell 376	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Forsyth Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

069

DEC 19 1952

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.

Student

Student Embalmer

Signed.....

Walter S Cobb

Licensed Embalmer No. 4731

P. O. Address Forsythe 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.