

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13000

State File No.

No. 300

10.48

FILED MAR 17 1953

BIRTH NO. _____ REG. DIST. NO. 348 PRIMARY REG. DIST. NO. 4509 Registrar's No. 83

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

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Humphrey</u>		c. LENGTH OF STAY (In this place) <u>Life</u>	
c. CITY (If outside corporate limits, write RURAL and give township) <u>Humphreys</u>		d. STREET ADDRESS (If rural, give location) <u>1050</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MINERVA</u> b. (Middle) <u>EULEN</u> c. (Last) <u>CUTSINGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-9-1953</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>2-2-1855</u>
9. AGE (In years last birthday) <u>98</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Edenburg Ind.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Gabe Lesley</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Much</u>	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <u>Dean Cutsinger</u>		ADDRESS <u>Humphrey 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 wk</u> ANTECEDENT CAUSES DUE TO (b) <u>Myocarditis Chronic</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) <u>4222</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-1-1925</u> to <u>3-9-1953</u> , that I last saw the deceased alive on <u>3-2-1953</u> , and that death occurred at <u>6:45 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>W.C. Weston M.D.</u>		23b. ADDRESS <u>Galt Mo</u>	
23c. DATE SIGNED <u>3-12-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-12-53</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Humphrey Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Humphrey Mo.</u>	
DATE REC'D BY LOCAL REG. <u>March 16</u>		REGISTRAR'S SIGNATURE <u>Greta Caldwell</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>PR Payne</u>		ADDRESS <u>Galt Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

P. K. Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.