

FILED JUL 6 1954

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17999

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 688

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission. a. STATE <u>Mo</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph</u>	c. LENGTH OF STAY (In this place) <u>3 1/2</u>	c. CITY OR TOWN <u>St Joseph</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital # 2</u>		e. STREET ADDRESS (If rural, give location) <u>521 Renick Street</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Gertrude</u>	b. (Middle) <u>Louise</u>	c. (Last) <u>Hussey</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6 26 1954</u>
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5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 9-1917</u>	9. AGE (In years - last birthday) <u>36</u>	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Atchison, Kansas.</u>	12. CITIZEN OF WHAT COUNTRY? <u>America</u>
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13a. FATHER'S NAME <u>Bert Marshall.</u>	13b. MOTHER'S MAIDEN NAME <u>Veda Griffith.</u>	14. NAME OF HUSBAND OR WIFE <u>Melvin Hussey</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>Not given</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Melvin Hussey</u>	ADDRESS <u>521 Renick City</u>
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar pneumonia both lungs</u>		<u>3 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>cerebral palsy</u>		<u>3 yrs +</u>
DUE TO (c) <u>Psychotic</u>		<u>3 yrs +</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 <u>490X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 6-26, 1954 to 6-26, 1954 that I last saw the deceased alive on 6-26, 1954 and that death occurred at 9 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>O. E. Cassine MD</u>	(Degree or title)	23b. ADDRESS <u>State Hospital # 2 City</u>	23c. DATE SIGNED <u>6-26, 1954</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 29/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>June 30, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M Allison</u>	485	25. FUNERAL DIRECTOR'S SIGNATURE <u>Herman H Sidenfaden</u>	ADDRESS <u>St. Joseph Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *Herman W. Sidenfaden*

Licensed Embalmer No. *272*

P. O. Address *St. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.