

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
State File No. 994
 BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 994

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Springfield
d. FULL NAME OF HOSPITAL OR INSTITUTION 736 S. Market		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) MARGARET		b. (Middle) E.	c. (Last) CUTBURTH
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	4. DATE OF DEATH (Month) (Day) (Year) October 27, 1954
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In Home	8. DATE OF BIRTH 22 Jan. 1857
13a. FATHER'S NAME Henderson Bass		13b. MOTHER'S MAIDEN NAME Mary Stratton	9. AGE (In years last birthday) 97
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. No	11. BIRTHPLACE (City and State or Foreign Country) Missouri
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.		12. CITIZEN OF WHAT COUNTRY? USA	
19a. DATE OF OPERATION		14. NAME OF HUSBAND OR WIFE Deceased	
19b. MAJOR FINDINGS OF OPERATION		17. INFORMANT'S SIGNATURE OR NAME Blanch Wiles ADDRESS Springfield, Mo.	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		18. MEDICAL CERTIFICATION	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia, acute	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		INTERVAL BETWEEN ONSET AND DEATH 3 da	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		21. DATE OF OPERATION 491 X	
22. I hereby certify that I attended the deceased from Oct 26, 1954 to Oct 27, 1954 , that I last saw the deceased alive on Oct 26, 1954 , and that death occurred at 2:50A m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Don J. Silsby M.D.		23b. ADDRESS Springfield Mo	
23c. DATE SIGNED OCT 28 1954			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24. LOCATION (City, town, or county) (State) Crane, Missouri	
24b. DATE 10/29/54		24c. NAME OF CEMETERY OR CREMATOR Masonic Cemetery	
DATE REC'D BY LOCAL REG. 10-29-54		25. FUNERAL DIRECTOR'S SIGNATURE Jenkins & Co. ADDRESS Springfield, Mo.	
REGISTRAR'S SIGNATURE Edith Williams			

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.....
Max R. [Signature]

Licensed Embalmer No..... 40

P. O. Address.....
[Signature]

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.