No. 300
10.48

FILED JAN 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1560

BIRTH NO. _____ REG. DIST. NO. 169 PRIMARY REG. DIST. NO. 4258 Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY Knox 0
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Edina
c. LENGTH OF STAY (in this place) 1 WK
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gibson Hospital & Clinic

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Knox
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baring 0520
d. STREET ADDRESS (If rural, give location) 0

3. NAME OF DECEASED (Type or Print)
a. (First) HAZEL
b. (Middle) IRENE
c. (Last) KUHN

4. DATE OF DEATH (Month) Jan (Day) 8 (Year) 1955

5. SEX F /
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married /
8. DATE OF BIRTH Feb 4, 1911
9. AGE (In years last birthday) 43 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Knox County 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Roy Little
13b. MOTHER'S MAIDEN NAME Grace Coy
14. NAME OF HUSBAND OR WIFE Frank Kuhn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 0
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Frank Kuhn Baring ADDRESS

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Paralysis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fulminating Bulbar Multiple Sclerosis — 15 yrs
~~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 345 X
20. AUTOPSY? YES ☐ NO ☒

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1951, *to* 1-8, 1955, *that I last saw the deceased alive on* 1-8, 1955, *and that death occurred at* 10:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) DO
23b. ADDRESS Edina Mo
23c. DATE SIGNED 1-10-55

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Jan 11, 1955
24c. NAME OF CEMETERY OR CREMATORY Greensburg cemetery
24d. LOCATION (City, town, or county) Greensburg, Mo (State)

DATE REC'D BY LOCAL REG. Jan 12 55
REGISTRAR'S SIGNATURE Nelle S. Hunolt
25. FUNERAL DIRECTOR'S SIGNATURE [signature] Edina Mo ADDRESS

(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 .....
Student Embalmer

Signed Mrs J. W. Hudson

Licensed Embalmer No. 2972

P. O. Address Edina 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.