

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29271**

FILED OCT 3-1955

BIRTH NO. _____ REG. DIST. NO. **73** PRIMARY REG. DIST. NO. **4133** **5270** Registrar's No. **78**

1. PLACE OF DEATH a. COUNTY Clay		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hearney		c. LENGTH OF STAY (in this place) 2 yrs	c. CITY OR TOWN Hearney
d. FULL NAME OF HOSPITAL OR INSTITUTION Clay County Home		f. STREET ADDRESS (If rural, give location) 600 E. 0	

3. NAME OF DECEASED (Type or Print) Allen	a. (First) Allen	b. (Middle)	c. (Last) Cuthbertson	4. DATE OF DEATH Sept 16 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct 16 1882	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	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) County Patient	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Clinton Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jason Cuthbertson	13b. MOTHER'S MAIDEN NAME Sarah Busch	14. NAME OF HUSBAND OR WIFE Don't know
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Claude Cuthbertson	ADDRESS Clayton 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Asthmatic Attack		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Allergy of some unknown kind. DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 241X		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) (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 **July**, 19**54**, to **Sept**, 19**55**, that I last saw the deceased alive on **Sept 16, 1955**, and that death occurred at **9 P** m., from the causes and on the date stated above.

23a. SIGNATURE Wm H Graham	(Degree or title) MD	23b. ADDRESS Liberty Mo	23c. DATE SIGNED 9/19/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept 18, 1955	24c. NAME OF CEMETERY OR CREMATORY Fairview Cem	24d. LOCATION (City, town, or county) (State) Hearney Mo.
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DATE REC'D BY LOCAL REG. Sept 21, 1955	REGISTRAR'S SIGNATURE Wm H Graham	491.	25. FUNERAL DIRECTOR'S SIGNATURE Leonard Fry	ADDRESS Hearney Mo
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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 *C. A. Wise*

Licensed Embalmer No. *257*
P. O. Address *Smith*

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.