

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35610**

FILED NOV 1 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 203

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Marshall, Mo.</u>	c. LENGTH OF STAY (in this place) township) <u>14 Days</u>	c. CITY OR TOWN <u>Rural</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>57.0</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>4 1/2 Miles South West of Shackelford, Mo.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Fredrick</u> b. (Middle) <u>Theorick</u> c. (Last) <u>Huesgen</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 20 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 30-1898</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>20</u>	IF UNDER 14 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Bonnots-Mill-Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joseph B. Huesgen</u>	13b. MOTHER'S MAIDEN NAME <u>Gertrude Koenigsfeld</u>	14. NAME OF HUSBAND OR WIFE <u>Amelia Huesgen</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>500-03-1695</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Amelia Huesgen-Shackelford, Mo.</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CARCINOMA Liver</u>		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) _____ DUE TO (c) <u>1561</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	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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct 18, 1955, to Oct 20, 1955, that I last saw the deceased alive on Oct 21, 1955, and that death occurred at 8 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James A. Reid MD</u>	23b. ADDRESS <u>Marshall Mo</u>	23c. DATE SIGNED <u>10-21-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/24/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park</u>	24d. LOCATION (City, town, or county) (State) <u>Marshall, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Oct 23-55</u>	REGISTRAR'S SIGNATURE <u>Cecil A. Reid</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Leslie Sweeney - Marshall, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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..... *J. Edwin Surrency*.....

Licensed Embalmer No. *2235*

P. O. Address. *Marshall*

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.