

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=60-020096**

FILED JUN 8 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 220 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SHELBY</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>		Length of stay in 1b <u>2 da</u>	c. CITY OR TOWN <u>SHELBOVILLE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. ELIZABETH</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELEAN</u> Last <u>CUSICIK</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 31, 1934</u>	9. AGE (last birthday) <u>26</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME AGENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EXTENSION</u>	11. BIRTHPLACE (City and state or country) <u>ADAIR COUNTY, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>WILLARD CUSICIK</u>		13b. MOTHER'S MAIDEN NAME <u>MARY MITCHELL</u>		14. NAME OF HUSBAND OR WIFE	
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>491-36-8294</u>		17. INFORMANT <u>Mrs. MARY CUSICIK</u> Address <u>Rd 5 KIRKSVILLE, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decongenestian</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Unknown Cause -</u>					
DUE TO (c) <u>Pan hypopituitarism + diabete mellitus</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>28 May 1960</u> to <u>30 May 1960</u> and last saw her/him alive on <u>30 May 1960</u> - Death occurred at <u>10:45 PM</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Wyneth Horman M.D.</u>			22b. ADDRESS <u>Hannibal mo</u>		22c. DATE SIGNED <u>6/4/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 2, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MADE Hill</u>		23d. LOCATION (City, town, or county) (State) <u>KIRKSVILLE MO.</u>	
24. FUNERAL DIRECTOR <u>Kelly Rogers</u> ADDRESS <u>Beashear, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6/6/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Rusche by William M. Horman</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JUN 14 19

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by This body was not embalmed in Hannibal, but, removed to, Braeshears Missouri Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *W. Crawford Smith*

Licensed Embalmer No. 7814

P. O. Address Hannibal Missouri

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.