

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025817

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 373 Primary Registration District No. 6265 Registrar's No. 39

FILED JUL 10 1962

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WEBSTER</b>                                      |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY <b>WEBSTER</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>GRANT TWP</b> |  | Length of stay in lb <b>9 YRS</b>  | c. CITY OR TOWN <b>STRAFFORD RI</b>                            |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION        |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <b>3 MI N.E.</b> |

|   |                                  |   |  |                                     |  |
|---|----------------------------------|---|--|-------------------------------------|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>CARRIE</b> Middle <b>A.</b> Last <b>SCHUSSELE</b> |                                  |   | 4. DATE OF DEATH<br>Month <b>JUNE</b> Day <b>18</b> Year <b>1962</b> |                                     |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-14-1884</b>                                | 9. AGE (last birthday)<br><b>77</b> | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min. |

|  |  |   |   |   |
|--|--|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>      |  | 10b. KIND OF BUSINESS OR INDUSTRY               | 11. BIRTHPLACE (City and state or country)<br><b>MISSOURI</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A</b>               |
| 13a. FATHER'S NAME<br><b>WILLIAM MOODY</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>ADDIE WHITE</b> |   | 14. NAME OF HUSBAND OR <del>WIFE</del><br><b>DIETRICH</b> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.                         | 17. INFORMANT<br><b>DIETRICH SCHUSSELE STRAFFORD</b>          |   |

|  |            |                                      |   |
|--|------------|--------------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |            |                                      | INTERVAL BETWEEN ONSET AND DEATH  |
| IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>  |            |                                      | <b>2 days</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) | <b>Anemia, primary and secondary</b> | <b>6 weeks</b>  |
|  | DUE TO (c) | <b>Leukemia, acute myelogenous</b>   | <b>6 weeks</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Chronic Granulocytic Leukemia (Splenomegaly) 10 yrs.</b> |            |                                      | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

|   |   |  |   |
|---|---|--|---|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____                       | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 6/8/55 to 6/18/62 and last saw her him alive on 6/16/62  
Death occurred at 210 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                               |  |   |                                    |
|---|-------------------------------|--|---|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>J. M. Macdonnell MD.</b> |                               | 22b. ADDRESS<br><b>Marshfield, Mo.</b>                 |   | 22c. DATE SIGNED<br><b>6/25/62</b> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>      | 23b. DATE<br><b>6-20-1962</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT PISGAH</b> | 23d. LOCATION (City, town, or county) (State)<br><b>WEBSTER CO MO</b> |                                    |
| 24. FUNERAL DIRECTOR<br><b>BARBER-EDWARDS MARSHFIELD</b>        |                               | 25. DATE RECD. BY LOCAL REG.<br><b>7-7-62</b>          | 26. REGISTRAR'S SIGNATURE<br><b>J. FRANCIS</b>                        |                                    |

USE BLACK INK OR TYPEWRITER RIBBON  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 [INSTEAD OF] [SHOULD READ]  
 DATE AMENDED  
 ITEM NO.

|           |       |
|-----------|-------|
| VS 300    |       |
| Rev. 4/59 |       |
| 1/10/20   |       |
| 2/10/20   |       |
| 3         |       |
| 4         | 1     |
| 5         | 1     |
| 6         |       |
| 7         | 0     |
| 8         | 2     |
| 9         | 204.3 |
| 10        |       |
| 11        |       |
| 12        | 90-0  |
| 13        | 3-0   |

**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 *R. W. Bowler*

Licensed Embalmer No. 3848

P. O. Address W. A. Groves Rd

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.