

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-037863

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 280

STATE FILE NUMBER

FILED OCT 29 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton		Length of stay in lb 16 yrs.	c. CITY OR TOWN City of St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) New St. Nicholas Hotel Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ARTHUR Middle JOSEPH Last CUSSEN		4. DATE OF DEATH Month October Day 20 Year 1962	
5. SEX Male	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 28 Feb. 1900
9. AGE (last birthday) 62		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (City and state or country) Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Patrick Joseph Cussen	
13b. MOTHER'S MAIDEN NAME Margaret Keenan		14. NAME OF HUSBAND OR WIFE Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Records of State Hospital No. 1, Fulton, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Brain Syndrome, Epilepsy			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 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 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. Attended the deceased from State Hospital No. 1 July 9, 1946 to Oct. 20, 1962 and last saw him alive on Oct. 20, 1962		Death occurred at 6:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <i>H. J. Frensch M.D.</i>		22b. ADDRESS State Hospital No. 1, Fulton, Mo.	22c. DATE SIGNED 10/22/62
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-22-62	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) Columbia, Mo.
24. FUNERAL DIRECTOR <i>Robert D. Johnston</i>	ADDRESS Columbia, Mo.	25. DATE RECD. BY LOCAL REG. Oct. 22-1962	26. REGISTRAR'S SIGNATURE <i>Martha Lawrence</i>

USE BLACK INK
OR
TYPEWRITER RIBBON

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.