

Registration District No. 85

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 43 days  
(Specify whether  
In this community 43 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County Buchanan  
(c) City or town St. Joseph "Rural"  
(If outside city or town limits write "RURAL")  
(d) Street No. Rural Route #1.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Joyce Marie Schussler 246

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 25 1940  
(Month) (Day) (Year)

8. AGE: Years 0 Months 1 Days 13 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Frank D. Schussler

18. Birthplace German town Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Juanita Goodrich

15. Birthplace Butler County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Schussler  
(b) Address R.R. #1 St. Joseph, Mo.

17. (a) Burial (b) Date thereof Aug. 9, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olivet Cemetery

18. (a) Signature of funeral director H.O. Sidenfaden & Son  
(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 8/18/40 (b) H. J. Nestlebury  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8th  
year 1940 hour 3 minute 40 A. M.

21. I hereby certify that I attended the deceased from June 25  
1940 to Aug 7, 1940  
that I last saw er alive on Aug 7  
and that death occurred on the date and hour stated above.

Immediate cause of death: Arterio-sclerosis.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: Arterio-sclerosis  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 85

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Frank D. Schussler (M. D. or other) \_\_\_\_\_  
Address Franklin Bldg Date signed 8/18/40

Duration

3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11  
5  
7

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Albert C. Harrington*

Licensed Embalmer No. 3258.

P. O. Address: St. Joseph, Mo.

**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 this body is not embalmed, above space should be left blank.**