

5. No. 2
-11-10-39
5-17-39
-I X2149-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43042

State File No.

JAN 20 1940
Registration District No. 470

Primary Registration District No. 5433

Registrar's No. 159

55

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Mount Vernon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 102 days
years, months or days) 3

3. (a) PRINT FULL NAME Albert Otis Cusick

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male

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 July 18 1919
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>21</u>	<u>5</u>	<u>4</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Clarence Cusick

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

14. Maiden name Unknown

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

16. (a) Informant Ethel McMichael, Record Clerk

(b) Address Mo. S.S. Mt. Vernon Mo

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof Dec. 24 40
(Month) (Day) (Year)

(c) Place: burial or cremation Buffalo, Mo.

18. (a) Signature of funeral director W. Jones, Funeral Home
Buffalo, Mo.

(b) Address _____

19. (a) 12-23-40 (Date received local registrar)

(b) P.A. HOLMES (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Lees Summit (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. R# 1
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22
year 1940 hour 3 minute 35 A. M.

21. I hereby certify that I attended the deceased from 9-12
1940, to 12-22, 1940
that I last saw him alive on 12-21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death For advanced Pulmonary Tuberculosis

Duration 6 mos

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? 421

(Specify type of place) _____
(e) While at work? _____ (f) Means of injury _____

23. Signature Samuel Brown (M. D. or other) Phys

Address Mt. Vernon Mo Date signed 12-22-40

RECEIVED

District Health Officer No. 6,

District File Number 141-67

Date Filed JAN 9 1941

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.....

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