

No. 2
1-13-40
1-17-39
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DEPARTMENT OF COMMERCE
Bureau of Health Statistics
FILED JAN 25 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43443**

Registration District No. **668**

Primary Registration District No. **3032**

Registrar's No. **374**

1. PLACE OF DEATH:

(a) County **Jettie**

(b) City or town **Sedalia, Mo.**

(c) Name of hospital or institution: **Bethwell Memo Hospital**
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution **4 hrs 30 min**
(Specify whether)

In this community **0**
years, months or days

3. (a) PRINT FULL NAME **MRS. KATHRINE Fuhs**

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **FEMALE** race **WHITE**

5. Color or race

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **EDWARD FUHS**

6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **OCT. 22 1876**
(Month) (Day) (Year)

8. AGE: Years **64** Months **2** Days **19** If less than one day hr. min.

9. Birthplace **FRANKLIN COUNTY IOWA**
(City, town, or county) (State or foreign country)

10. Usual occupation **Wife**

11. Industry or business

12. Name **THOMAS DOLSON**

13. Birthplace **PENN.**

14. Maiden name **MARY CROWE**

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

16. (a) Informant **EDWARD FUHS**

(b) Address **COUNCIL BLUFF IOWA**

17. (a) **BURIAL** (b) Date thereof **12-6-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation **COUNCIL BLUFF IOWA**

18. (a) Signature of funeral director **Mrs. Laughlin Cross**

(b) Address **Sedalia Mo 6450**

19. (a) **12/3/40** (b) **Mrs. Harry S. ...**
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **IOWA** (b) County **POTTAWATTAMIE**

(c) City or town **COUNCIL BLUFF**
(If outside city or town limits, write "RURAL")

(d) Street No. **1568 MADISON AVE.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **3** year **1940** hour **3** minute **0** M.

21. I hereby certify that I attended the deceased from **Dec 3**, 19**40**, to **Dec 3**, 19**40**

that I last saw **her** alive on **Dec 3**, 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Broken back**

Due to **auto wreck**

Due to **car leaving highway**

Other conditions (include pregnancy within 3 months of death) **Fract 4 ribs - the dorsal**

Major findings: Of operations

Of autopsy **2 ID M 25**

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 **Dec 3 - 40**

(c) Where did injury occur? **near Marlow, Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **highway 66**

While at work? **no** (Specify type of place) (e) Means of injury **accident**

23. Signature **M.P. Sly** (M. D. or other) **!**

Address **Sedalia Mo** Date signed **12-3-40**

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

0
14

40

1937 28 431

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-14-41

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 Robert H. Reed
Licensed Embalmer No. 3745
P. O. Address Sedalia, 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, fact should be so stated above.