S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 26 1947

Registration District No. 74

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3026

State File No. 9525

Registrar's No. 71

1. PLACE OF DEATH:

(a) County JACKSON

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

(c) Name of hospital or institution:
INDEPENDENCE SANITARIUM & HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution SIX DAYS
In this community 45 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town INDEPENDENCE 4
(If outside city or town limits, write "RURAL")

(d) Street No. 906 W. MAPLE AVE. 4
(If rural, give location) 2

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MRS. EVA E. CUSTEAD

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband ~~or wife~~
WILLIAM CUSTEAD

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

7. Birth date of deceased 10 (Month) 22 (Day) 1867 (Year)

8. AGE: Years 79 Months 4 Days 16 If less than one day ____ hr. ____ min.

9. Birthplace NEWTON (RHODES-JASPER CO.) IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business NONE

FATHER
12. Name I. N. WHITE
13. Birthplace NO RECORD
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name EMILY ------
15. Birthplace NO RECORD
(City, town, or county) (State or foreign country)

16. (a) Informant JACK CUSTEAD
(b) Address 934 S. MAIN

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3 - 11 - 47 (Month) (Day) (Year)
(c) Place: burial or cremation MOUND GROVE CEMETERY

18. (a) Signature of funeral director [signature]
(b) Address 815 W. MAPLE AVE.

19. (a) 3-15-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 8 year 1947 hour 4 minute 05 P.M.

21. I hereby certify that I attended the deceased from 1/17/47, 19__, to 3/8/47, 19__; that I last saw her alive on 3/8/47, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Terminal Bronchopneumonia	2 days
Due to: Cerebral hemorrhage with right hemiplegia	6 days
Due to: —	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations — 43A
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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Vance B. Link, M. D. (M. D. or other)
Address 129 W. Lexington St. Independence, Mo. Date signed 3/10/47

354 (Licensed Embalmer's Statement on Reverse Side)

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. 3156

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.