

Doctor, coroner, etc. must use only standard nomenclature in their reports. Symptoms will be stated. Cause of death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

FILED APR 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8104
STATE FILE NUMBER

Registration District No. 96 Primary Registration District No. 4158 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Buffalo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Buffalo 0308</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u> Length of stay in 1b <u>life</u>		d. STREET ADDRESS <u>Main</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Josie Elizabeth Cusick</u> First <u>Josie</u> Middle <u>Elizabeth</u> Last <u>Cusick</u>			4. DATE OF DEATH <u>March 31, 1957</u> Month <u>March</u> Day <u>31</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1883</u>	9. AGE (In years last birthday) <u>73</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own house</u>		11. BIRTHPLACE (City and state or country) <u>Henry Co. Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Fielden James</u>		
14. MOTHER'S MAIDEN NAME <u>Belle Depew</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>---</u>			17. INFORMANT <u>Goldie Harmon</u> Address <u>Buffalo, Mo.</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchial Pneumonia</u>		<u>4-5 d</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cardiovascular Renal dis</u>	<u>8-10 yr</u>
	DUE TO (c) <u>arterio sclerosis</u>	<u>10-12 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a. m. p. m.		
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. I attended the deceased from <u>Jan 1950</u> to <u>31 Mar 57</u> and last saw <u>her</u> alive on <u>30 Mar 57</u> Death occurred at <u>12 o'clock</u> pm on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Dr. Bruffen</u>	22b. ADDRESS <u>Buffalo Mo</u>	22c. DATE SIGNED <u>4 Apr 57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-2-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>	23d. LOCATION (City, town, or county) (State) <u>Dallas County, Mo.</u>
24. FUNERAL DIRECTOR <u>Jones of Buffalo, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4/8/57</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Grace Petree</u>

(Licensed Embalmer's Statement on Reverse Side)

APR 12 1957

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.....*Gene C. Hunt*

Licensed Embalmer No. *449*

P. O. Address *Buffalo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.