

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008680

STATE FILE NUMBER

FILED MAR 18 1959 Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Highway Austin Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Kansas City 3768</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>MILE NO OF ARCHIE</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>5811 Wabash</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>BILLY GENE TSCHUDI</u>			4. DATE OF DEATH Month Day Year <u>Mar 7 1959</u>		
5. SEX <u>Male</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>June 14 1934</u>	9. AGE (In years last birthday) <u>24</u>	FUNDER 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>Assembly man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fish &amp; Boat Co.</u>	11. BIRTHPLACE (City and state or country) <u>Cass Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Orville Lee Tschudi</u>		13b. MOTHER'S MAIDEN NAME <u>Bertha May Bryant</u>		14. NAME OF HUSBAND OR WIFE <u>Shirley Tschudi</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>Yes Nov 55 to Nov 57</u>		16. SOCIAL SECURITY NO. <u>486-36-7707</u>	17. INFORMANT <u>Shirley Tschudi</u> Address <u>5811 Wabash KCMo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral fracture with complete</u>		INTERVAL BETWEEN ONSET AND DEATH <u>0</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>contusion of brain</u>	
	DUE TO (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" 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.) <u>Auto accident</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>9:00 PM 12/59</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway #71</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Archie Cass Mo</u>
21. I attended the deceased from _____, to _____ and last saw <sup>her</sup> / <sub>him</sub> alive on _____ Death occurred at <u>7:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>J. E. Cor m. D.</u>	22b. ADDRESS <u>Placant Hill new</u>	22c. DATE SIGNED <u>3/2/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 10 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orient cemetery</u>	23d. LOCATION (City, town, or county) (Specify) <u>Harrisonville Mo.</u>
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24. FUNERAL DIRECTOR <u>Burien Smyth</u>	ADDRESS <u>Harrisonville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-9-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ray Sebrer</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard manufacturer's materials. All diseases in Part I must be causally related.

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-57  
-3

6661 8 2 NOV  
1959  
8961 7 2 NOV

EMERALD DEPARTMENT

MAY 19 1959

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 Frank E. Runnenbarger 3<sup>rd</sup>, Student Embalmer No. 568 working under my personal supervision.

Student Frank E. Runnenbarger 3<sup>rd</sup> Signed James P. Phillips  
Signature of Student Embalmer

Licensed Embalmer No. 4641  
P. O. Address Norisonville, TN

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.