

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 23 1959

'59 043541

Registration District No. _____ Primary Registration District No. 4066 Registrar's No. 38 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Caldwell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Caldwell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kingston</u>		Length of stay in 1b	c. CITY OR TOWN <u>Polo</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>Berry Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Henry H.</u> Middle <u>J.</u> Last <u>Zusck</u>			4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 8-1872</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>27</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Caldwell Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <u>John Zusck</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Lindsey</u>		14. NAME OF HUSBAND OR WIFE <u>Ramie Zusck (Dee)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service)		16. SOCIAL SECURITY NO. <u>L</u>		17. INFORMANT <u>Wm H. Zusck, (son) Polo Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerotic heart disease</u>	
DUE TO (c)		<u>10 yrs.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Duodenal Ulcer</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m. Month, Day, Year _____			

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 <u>Kingston</u>	COUNTY <u>Caldwell Mo.</u>	STATE
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21. I attended the deceased from 1955 to 12-5-59 and last saw ^{from} him _{live on} 12-5-59
Death occurred at 9 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank R. Daley, M.D.</u> (Degree or title)	22b. ADDRESS <u>Hamilton Mo.</u>	22c. DATE SIGNED <u>12-9-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prairie Ridge Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Rockford Twp Caldwell Mo</u>
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24. FUNERAL DIRECTOR <u>Alsprang & Cowley Polo Mo</u>	ADDRESS <u>12-18-59</u>	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>Gladys Jones</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signed Ernest Mowbray

Signature of Student Embalmer

Licensed Embalmer No. 4924

P. O. Address Polo, Mo

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