

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-043046

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 589

STATE FILE NUMBER

FILED DEC 7 1962

VS 300
Rev. 4/59

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20300

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		Length of stay in 1b <u>2 Mo</u>	c. CITY OR TOWN <u>Buffalo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cable Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8 mi north</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Cusick</u>		4. DATE OF DEATH Month Day Year <u>Dec. 5 - 1962</u>	

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-1886</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Dallas Co Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Richard Cusick</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Griner</u>		14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT Address	

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediately</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>cerebral arteriosclerosis</u>		<u>undetermined</u>
DUE TO (c) <u>generalized arteriosclerosis</u>		<u>undetermined</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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	COUNTY	STATE
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21. I attended the deceased from 9/22/62 to _____ and last saw her/him alive on 11/23/62
Death occurred at 2:00 p.m. 12/5/62 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Alba L. Craig M.D.</u>	22b. ADDRESS <u>10901 Winner Road</u>	22c. DATE SIGNED <u>12/5/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-7-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>	23d. LOCATION (City, town, or county) (State) <u>Buffalo Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Angelof Funeral Home - Lees Summit Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-5-62</u>	26. REGISTRAR'S SIGNATURE <u>Alba L. Craig</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

12-5-62
Dr. Fouts and wife

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 *W. R. Kingford*
Licensed Embalmer No. 3253

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