

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000538

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 34

FILED FEB 11 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	SHOULD READ	ITEM NO.	BY AFFIDAVIT OF
8147								
2808								
3								
4 0								
5 1								
6								
7 0								
8 1								
9501X								
10								
11								
12 93-0								
13 1-0								

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Missouri Fulton</u>		c. CITY OR TOWN <u>Sedalia</u>	
Length of stay in lb <u>5 days</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>		d. STREET ADDRESS- <u>255 E. Boonville</u> (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>CUSICK</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1963</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>8-7-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	9. AGE (last birthday) <u>77</u>
11a. FATHER'S NAME <u>W.T. Cusick</u>		11b. MOTHER'S MAIDEN NAME <u>Mary Jane Parsley</u>	
11c. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>unk</u>		Address <u>State Hospital No. 1, Fulton, Mo.</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>Lungs - bilateral bronchopneumonia</u> DUE TO (b) <u>Bronchi - hemorrhagic bronchitis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>lungs - emphysema</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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.	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>State Hospital No. 1</u>		COUNTY <u>Fulton</u> STATE <u>Missouri</u>	
21. X attended the deceased from <u>1-29-1963</u> to <u>2-5-1963</u>		Death occurred at <u>12:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Fred P. Handley MD</u>		22b. ADDRESS <u>Fulton, Missouri</u>	
22c. DATE SIGNED <u>2/5/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>FEB 7-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND MEMORIAL GARDENS</u>	
23d. LOCATION (City, town, or county) <u>SEDALIA MO</u>			
24. FUNERAL DIRECTOR <u>Duane Ewing</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 5. 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>			

USE BLACK INK OR TYPEWRITER RIBBON

FEB 14 1963

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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 R. E. Baker

Licensed Embalmer No. 2419

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