

No. 2
M-5-43
5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4611**
Registrar's No. **16**

FILED MAR 14 1947
Registration District No. **133**

Primary Registration District No. **3022**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **HARRISON**

(b) City or town **BETHANY**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
BETHANY HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 DAYS**
(Specify whether years, months or days)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **HARRISON** **41**

(c) City or town **BETHANY**
(If outside city or town limits, write "RURAL") **5**

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **JOHN HYDEN CUDDY**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **MO** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **EVA** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 13 1875**
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | 71 | 6 | 21 | _____ hr. _____ min. |

9. Birthplace **VIRGINIA**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED MERCHANT**

11. Industry or business _____

MOTHER FATHER { 12. Name **DAVID CUDDY**

{ 13. Birthplace **DO NOT KNOW** **9**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **MARY DUNN**

{ 15. Birthplace **DO NOT KNOW** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Eva Cuddy**

(b) Address **Bethany, Mo.**

17. (a) **BURIAL** (b) Date thereof **Feb 6 - 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BETHANY, MO.**

18. (a) Signature of funeral director **Thomson H. Haas**

(b) Address **Bethany, Mo.**

19. (a) **Feb. 18 47** (b) **Gola Burris**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEB.** day **4**
year **1947** hour **6** minute **P.M.**

21. I hereby certify that I attended the deceased from **Jan 13**
1947 to **Feb. 4**, 1947,
that I last saw him alive on **Feb 4**, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage -**

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature **W. F. Broyles** (M. D. or other) **0**

Address **Bethany Mo.** Date signed **2/6/47**

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APR 4 1947

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Thornton H. Haas*

Licensed Embalmer No. *2861*

P. O. Address..... *Bethany, 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 this body is not embalmed, fact should be so stated above.