JUL 25 1929 Dr Powers

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

21848

1. PLACE OF DEATH
County Jasper — Registration District No. 411 — File No.
Township — Primary Registration District No. 2002 — Registered No.
City Joplin (No. ..... St. ..... Ward)

2. FULL NAME Delia Busby
(a) Residence. No. Freeman Hospital Ward. Anderson Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Wm Busby
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 14 - 1901
7. AGE: YEARS 28 — MONTHS 4 — DAYS 11 — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN): Ottawa Co
(STATE OR COUNTRY): Okla

PARENTS
10. NAME OF FATHER: Robert Schmidt
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Nettie Hatfield
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Mo.
(STATE OR COUNTRY)

14. INFORMANT: Robert Schmidt
(Address) Anderson Mo R1
15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 25 1929
17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929 to June 25, 1929 that I last saw her alive on June 25, 1929, and that death occurred, on the date stated above, at 1:30 P.M.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
102
13-A
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (SECONDARY): ~~Nep~~ Pyelitis
(duration) ..... yrs. ..... mos. 10 ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory & X Ray
(Signed) H C Powers, M.D.
6/26, 1929 (Address) Joplin Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Anderson Mo — DATE OF BURIAL: June 26 1929
20. UNDERTAKER: Geo Tatum Mer Co — ADDRESS: Anderson Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Jasper — Registration District No.: 411 — File No.:
Township: — Primary Registration District No.: 2002 — Registered No.:
City: Joplin (No. ..., St. ..., Ward)

2. FULL NAME: Delia Busby
(a) Residence. No. ..., St., ..., Ward. ...
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 7-5, 1929 — A Benson Clerk — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1929

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ...m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

... (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (SECONDARY) ... (duration) ...yrs. ...mos. ...ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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