

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MAR 24 1934

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

Do not use this space.

7396

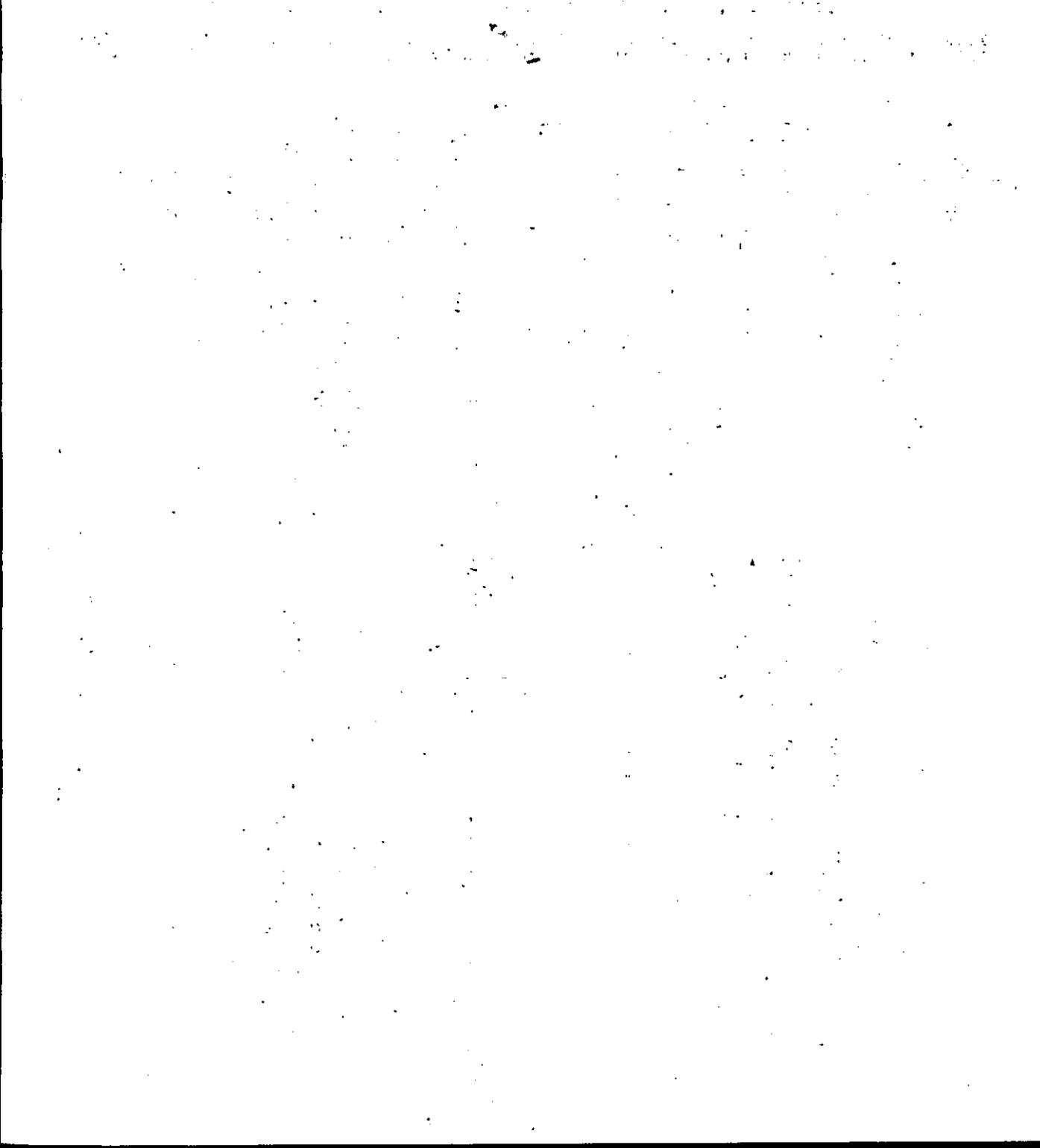
1. PLACE OF DEATH
 97 County Saline Registration District No. 796
 6 Township _____ Primary Registration District No. 3038
 7 City Marshall, Mo. (No. _____) St. _____ Ward _____
 2. FULL NAME Mrs Cassie Bush
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give 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 Female
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Grant Bush
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 23, 1861
 7. AGE YEARS 72 MONTHS 6 DAYS 13 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housekeeper
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Martha Bend, Mo.
 MOTHER FATHER
 13. NAME James L. Denison
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee
 15. MAIDEN NAME Malinda Brazill
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee
 17. INFORMANT Grant Bush
 (ADDRESS) Martha Bend, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Martha Bend, Mo. DATE Feb. 6 1934
 19. UNDERTAKER J. L. Swanson
 (ADDRESS) Martha Bend, Mo.
 20. FILED 2/6 1934 - Platner Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 5 1934
 22. I HEREBY CERTIFY, That I attended deceased from Jan. 9 1934 to Feb 5 1934
 I last saw him alive on Feb 5 1934. Death is said to have occurred on the date stated above, at 5:00 a. m.
 The principal cause of death and related causes of importance were as follows:
Chronic nephritis 1925
Hypostatic pneumonia Feb. 4, 1934
 Other contributory causes of importance: _____
 Name of operation oblation Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Allison Marshall, M.D.
 (Address) Marshall, Mo.



#2 *Saline*

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS *7396*

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Mrs. Cassie Bush*
Who died at _____ on *Feb-5-1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *F* Color or race *W* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *42* Months *6* Days *13*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month *12* Year *1934*

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: *Chronic Catarrhis (Cholecystitis) with gall stones.*

Other contributory causes of importance *Hypostatic Pneumonia*

Name of operation *Cholecystotomy* Date of _____ *1-25-34*

What test confirmed diagnosis? *Autopsy* Was there an autopsy? *W*

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar *H.P. Bouway* Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *796* Very truly yours,

Primary Reg. Dist. No. *3038*

E. T. McGaugh M.D.
Special Agent.

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