

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

Do not use this space.

DEC 26 1935

36245

1. PLACE OF DEATH

County Jackson Registration District No. 300 File No. _____
 Township Kaw Primary Registration District No. 1500 Registered No. _____
 City Kansas City (No. 2900 Harrison) St. 4th Ward

2. FULL NAME Mellie E. Bush

(a) Residence, No. 2900 Harrison St. _____ Ward. _____ (If nonresident, give city or town and State)
 (Usual place of abode)

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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 4, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 3 19

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At home
 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) Illinois

13. NAME John W. Bush

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

15. MAIDEN NAME Margaret Chamber

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT Mrs. Donald Bush
 (ADDRESS) 2900 Harrison

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE Nov. 26, 1935

19. UNDERTAKER Stine & McClure
 (ADDRESS) 3235 Gillham Plaza

20. FILED 11-25-35 M. M. Crowe
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 23, 1935

22. I HEREBY CERTIFY, That I attended deceased from July 4, 1934, to Nov 23, 1935.
 I last saw him alive on Nov 22, 1935. Death is said to have occurred on the date stated above, at A. M. 6:50

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis Date of onset _____
myocarditis

Name of operation none Date of none

What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury no, 1935
 Where did injury occur? no
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. no

Manner of injury none
 Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) J. F. Mackey, M. D.
 (Address) Professional Bldg.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 4473
 City..... (No)..... St..... Ward)

2. FULL NAME

Mellie B 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 ♀ 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word).....

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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

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).....

13. NAME.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

15. MAIDEN NAME.....

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL PLACE..... DATE.....19.....

19. UNDERTAKER (ADDRESS).....

20. FILED 11-25-35 Dr. M. Grove Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-23-35

22. I HEREBY CERTIFY, That I attended deceased from..... to....., 19..... I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:
Arteriosclerosis

Other contributory causes of importance:
Myocarditis Chronic

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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)....., M. D. (Address).....

SUPPLEMENTARY

REVISIONS ARE COMPLETED BY LAW.

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