

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

1939 OCT 15 1939

Registration District No. 775

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33390

Primary Registration District No. 6070-A

Registrar's No. 70

1. PLACE OF DEATH:  
 (a) County St. Francois  
 (b) City or town Bonne Terre, Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution Bonne Terre Hospital  
 (If not in hospital or institution, write street number & location)  
 (d) Length of stay: In hospital or institution 1 day (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days) 9 2 2

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Ohio (b) County \_\_\_\_\_  
 (c) City or town Paulding  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mark Bustos  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Mexican 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Adelia Bustos 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Sept 5 1882  
 (Month) (Day) (Year)

8. AGE: Years 57 Months 0 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Sanguin, Mexico  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Unknown

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name Cabrera Montigand

15. Birthplace Mexico  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Bustos  
 (b) Address Paulding, Ohio

17. (a) Burial (b) Date thereof 9-25-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Berham Hall Co  
 (b) Address 313 Benton St Bonne Terre  
 19. (a) Sept. 25 1939 (b) M. W. Humbert  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Sept day 23rd  
 year 1939 hour 6:10 minute a. M.  
 21. I hereby certify that I attended the deceased from 9-22- 1939, to 9-23- 1939;  
 that I last saw him alive on 9-23- 1939;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Intraocular hemorrhage Duration 2 da.  
 Due to Fractured skull

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) Accident (auto)  
 (b) Date of occurrence 9-22-39  
 (c) Where did injury occur? U.S. Highway 61 South  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
of St. Louis, Mo  
 (Specify type of place)  
 While at work? no (e) Means of injury lorry

23. Signature H. W. Roebber (M. D. or other) M.D.  
 Address Bonne Terre, Mo Date signed 9-23-39

11/12/12  
0088

**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..... *C. J. Claywell* .....

Licensed Embalmer No. *3706*

P. O. Address. *Brownsville, TX*

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

33390

Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 775-  
(b) Township Bonne Terre Primary Registration District No. 6020A Registered No. ....  
(c) City Bonne Terre (d) Street No. .... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mike Bustos

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Mex 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 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.  
27 0 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-23, 1939

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:

Intra-Cranial Hemorrhage  
fractured skull  
Date onset 9-18  
Other contributory causes of importance: Collision with other motor vehicle

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 auto accident  
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify  
(Signed) H. M. Roebber, M. D.  
(Address) Bonne Terre Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

