

1-40
-39
22159

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Kansas
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 12 hours
(Specify whether

In this community
years, months or days

3. (a) PRINT FULL NAME Edward Le Roy Bushman

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased September 20 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 12 hr. _____ min.

9. Birthplace Clinton Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name Roy Bushman

13. Birthplace Bakersburg Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Steadys Hawkins

15. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Roy Bushman

(b) Address Clinton Mo.

17. (a) Burial (b) Date thereof Sept 21, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton Missouri

18. (a) Signature of funeral director Spore & Son

(b) Address Clinton Mo.

19. (a) 9-21-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Clinton
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 21 1940
year _____ hour _____ minute 18 M.

21. I hereby certify that I attended the deceased from 9-20-40, 19____, to 9-21-40, 19____; that I last saw him alive on 9-29-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death
Total Atherosclerosis of Arteries

Due to Cord Compression

Due to _____ 10/31

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

367 (Specify type of place) While at work _____ (e) Means of injury _____

23. Signature Dr. J. W. Brown (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.