

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **39816**

Registration District No. **782**

Primary Registration District No. **114**

Registrar's No. **2091**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Shrewsbury
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
7833 Grove Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME J. George Rush

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Madeline Rush

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased May 28, 1883
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>5</u>	<u>9</u>	hr. _____ min.

9. Birthplace Columbus, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Leather Products

MOTHER FATHER

12. Name John Rush

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

14. Maiden name Mary Farrell
(City, town, or county) (State or foreign country)

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

16. (a) Informant Madeline Rush (wife)

(b) Address 7833 Grove Ave.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Nov. 9, 1940
(Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter & Paul

18. (a) Signature of funeral director [Signature]

(b) Address 7146 Manchester Ave.

19. (a) NOV 6 1940
Date received local registrar)

(b) [Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Shrewsbury
(If outside city or town limits, write "RURAL")

(d) Street No. 7833 Grove Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6th
year 1940 hour 9 minute 0 A. M.

21. I hereby certify that I attended the deceased from Sept 25th 1940 to Nov 6th 1940
that I last saw him alive on Nov 6th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
arterio-sclerotic heart disease
general

Due to _____

Due to _____

Other conditions general
(Include pregnancy within 3 months of death)

Major findings: 95% 2
Of operations _____

Of autopsy Coronary occlusion
infarcted in heart.

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? _____

23. Signature [Signature]
(Specify type of place) (e) Means of injury _____

Address Webster St Date signed _____

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

Francis A. Williamson

Licensed Embalmer No.

3565

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.

Registration District No. 784

Primary Registration District No. 114

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Shrewsbury
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME John George Bush

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 57 Months 5 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Proglum H 1470

(b) Address _____

19. (a) 11-6-40 (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
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) _____
(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? _____

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

23. Signature Wm A Smith M. D. or other _____
Address Deaton Date signed _____

SUPPLEMENTARY

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

MOTHER, FATHER

1940

S-39816