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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41176

State File No. ....

JAN 8 1944

Primary Registration District No. 1002

Registrar's No. 4569

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
626 E 73rd Terrace  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Catherine Bush

(b) If veteran, name war No

(c) Social Security No. No

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased 3 - 5 - 1852  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>88</u>	<u>8</u>	<u>34</u>	hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER

12. Name Elizabeth

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

14. Maiden name May Jane Patton

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

16. (a) Informant E. E. Bush

(b) Address 932 Lombardy

17. (a) Rural (b) Date thereof 12-1-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Topha, Kansas

18. (a) Signature of funeral director J. C. ...

(b) Address 12. City

19. (a) 12/1/40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 626 E 73rd Terrace  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 29  
year 40 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from 1937  
\_\_\_\_\_, 19\_\_\_\_, to 11/29/40, 19\_\_\_\_;  
that I last saw her alive on 11/27/40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death hypostatic pneumonia

Due to myocardial insufficiency

Due to MI

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? 361

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 3

23. Signature Olaf Coleman, M. D. or other OO  
Address 6227 E 15th Date signed 11/29/40

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**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 with the above constitutes grounds for revocation of license.)**

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