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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33997

Registration District No. 399 — Primary Registration District No. 1602 — Registrar's No. 3937

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

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days; In this community Over 60 Yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: Milner Hotel, 9th & Central
(If rural, give location)
(e) If foreign born, how long in U. S. A.? x years.

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3. (a) PRINT FULL NAME: Mrs. NELLIE MERRILL (Bushnell)

3. (b) If veteran, name war: x

3. (c) Social Security No.: x

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Horace Bushnell,

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

7. Birth date of deceased: June (Month) 24th (Day) 1860 (Year)

8. AGE: Years 81 Months 3 Days 27 If less than one day ___ hr. ___ min.

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

10. Usual occupation: at home,

11. Industry or business: x

FATHER
12. Name: William Schley,
13. Birthplace: Unknown, (City, town, or county) (State or foreign country) 4

MOTHER
14. Maiden name: Armenta Lamoreaux,
15. Birthplace: Unknown, (City, town, or county) (State or foreign country) 4

16. (a) Informant: Preston Merrill,
(b) Address: Milner Hotel, Kansas City, Mo.

17. (a) Burial, (Burial, cremation, or removal) (b) Date thereof: 10-23-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Elmwood Cemetery,

18. (a) Signature of funeral director: Stine & McClure,
(b) Address: 3235 Gillham Plaza, K. C., Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20th year 1941 hour 7:00 P.M. minute ___ M.

21. I hereby certify that I attended the deceased from 10-12-41, 19__, to 10-20-41, 19__; that I last saw her alive on 10-20-41, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial insufficiency and Senility	
Due to: 93E2	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: —
Of autopsy: None

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: x

23. Signature: Drury R. Thorn (M. D. or other) 0
Address: Med. Dir. K.C. Gen. Hospital K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Willis H. Bennett, Registered Apprentice No. 282 working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 1415

P. O. Address [illegible]

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

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

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33997

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3937

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: (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 years, months or days)

In this community: (Bushnell)

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:

3. (a) PRINT FULL NAME: Nellie F. Merrill

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

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

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

7. Birth date of deceased: June 24 1860 (Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 7 (If less than one day) hr. min.

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

10. Usual occupation:

11. Industry or business:

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation:

18. (a) Signature of funeral director:

(b) Address:

19. (a) Jan. 29, 1942 (Date received local registrar) (b) Margaret R. Gross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. Day 29 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h. alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

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: (M. D. or other)

Address: Date signed:

SUPPLEMENTARY