

No. 5-42
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 675

FILED FEB 27 1943
Registration District No. 1799

Primary Registration District No. 1002

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: 409 E 4th
(If not in hospital or institution, write street number or location)

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

In this community unknown years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 409 E 4th
(If rural, give location)

(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN BUSHART

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

4. Sex Male 5. Color W 6. (a) Single, widowed, married, divorced unknown

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

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

8. AGE: Years Months Days If less than one day
about 75 yrs hr. min.

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

10. Usual occupation none

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Coroner's office
(b) Address Court Hotel

17. (a) Removal (b) Date thereof 2-15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation KC Plbg of Osteopaths

18. (a) Signature of funeral director Beta B. ...
(b) Address K.C. Mo

19. (a) 2-9-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 21
year 1943 hour 11:50 minute 0 M.

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

Immediate cause of death Arterio-sclerotic heart disease

Due to _____
Due to _____

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

Major findings: _____
Of operations _____
Of autopsy inspection of history

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)

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 [Signature] (M: D. or other) _____
Address K.C. Mo Date signed 2/28/43

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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(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.....
....., Registered Apprentice No.
working under my personal supervision.

Signed *Don B. Carpenter*
Licensed Embalmer No. *4773*
P. O. Address *KCMo*

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.