S. No. 2
I—9-4-41
6-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

9374

State File No.

FILED MAR 16 1943

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 34

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

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Grim-Smith Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 days (Specify whether

In this community 40 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105

(c) City or town Green City 0 (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME NORA Bell BUSHONG

3. (b) If veteran, name war ✓

3. (c) Social Security No.

4. Sex F

5. Color or race wh

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

6. (b) Name of husband or wife S.A. Bushong

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased May (Month) 11 (Day) 1875 (Year)

8. AGE: Years 67 Months 8 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name G. B. Eubank
13. Birthplace (City, town, or county) Tenn (State or foreign country) 1

MOTHER
14. Maiden name Mary Garrett
15. Birthplace (City, town, or county) Tenn (State or foreign country) 1

16. (a) Informant S.A. Bushong

(b) Address Green City, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (Month) 10 (Day) 1943 (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Glenn E Kent & Son

(b) Address Green City, Mo

19. (a) 2/9/43 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

1049

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8 year 1943 hour 7 minute 40 a M.

21. I hereby certify that I attended the deceased from Jan 14, 1943 to Feb 8, 1943 that I last saw her alive on Feb 8, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	3 days
Due to Congestive heart failure	
Due to Rheumatic heart disease	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. S. Smith (M. D. ~~or other~~)

Address Kirksville Date signed 2/8/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 3-43-572
Date Filed MAR 12 1943

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Greenville, N

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
OM—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. 9374

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 34

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Grim Smith Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 days. (Specify whether
In this community 40 yrs.
years, months or days)

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 Nora Bell Bushong

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 11 (Day) 1875 (Year)

8. AGE: Years 67 Months 8 Days 21 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8
year 1943 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 Uremia Chronic Congestive heart failure — Duration 3 days

Due to Rheumatic heart disease

Due to Not known

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

23. Signature E. S. Smith (M. D. ~~or other~~)
Address Date signed

SUPPLEMENTARY