

FILED MAR 6, 1945

Registration District No. Primary Registration District No. *4180* Registrar's No.

1. PLACE OF DEATH:

(a) County *Franklin*

(b) City or town *St. Clair* MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *1*
(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) *2 days*

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Franklin*

(c) City or town _____ (If outside city or town limits, write "RURAL") *36*

(d) Street No. _____ (If rural, give location) *3*

(e) Citizen of foreign country? *NO* (Yes or No) *0*
If yes, name country _____

3. (a) PRINT FULL NAME *Melvin Bussé*

3. (b) If veteran, name war *NO* 3. (c) Social Security No. *None*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, widowed, married, divorced *single*

6. (b) Name of husband or wife *None* 6. (c) Age of husband or wife if alive *None* years

7. Birth date of deceased *6 27 1924*
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* - day *18* year *1945* hour *1* minute *40* M.

21. I hereby certify that I attended the deceased from *Jan-16* to *Jan-18* 19*45* that I last saw him alive on *Jan-18* 19*45* and that death occurred on the date and hour stated above.

Immediate cause of death: *Tuberculosis of lungs*

8. AGE: Years Months Days If less than one day

20 6 25 hr. min.

Due to _____ *3425-*

Due to _____

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

Major findings: *1 3 1*

Of autopsy _____

9. Birthplace *Morrellton* MO (City, town, or county) (State or foreign country)

10. Usual occupation *Laborer*

MOTHER FATHER

11. Industry or business _____

12. Name *Louis Bussé*

13. Birthplace *Morrellton* MO (City, town, or county) (State or foreign country)

14. Maiden name *Willy Williard*

15. Birthplace *Centar* MO (City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant *Ruby Miller* MO (b) Address *St. Clair*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *7-20-45* (Month) (Day) (Year)

(c) Place: burial or cremation *Morrellton, Kentucky*

18. (a) Signature of funeral director *W. E. Ketchell* (b) Address *St. Clair, MO*

19. (a) *1/19/1945* (Date received local registrar) (b) *W. E. Ketchell* (Registrar's signature)

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) _____ Mean of injury _____

23. Signature *W. E. Ketchell* (M. D. or other) *1/19/45*
Address *St. Clair, MO* Date signed *1/19/45*

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

RECEIVED

District Health Officer No. 9

District File Number

Date Filed

3-5-45

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

Geo L. Hughes
Licensed Embalmer No. 3008

P. O. Address

Pacific Mo

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 113

Primary Registration District No. 4185

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
 (b) City or town St. Clair
(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 Melvin Busse

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

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

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

7. Birth date of deceased June 27
(Month) (Day) (Year)

8. AGE: Years 20 Months _____ Days _____
If less than one day, hr. _____ min. _____

9. Birthplace Mo.
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin
 (c) City or town St. Clair Mo.
(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 January day 18
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____

that I last saw him _____ 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 _____

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

SUPPLEMENTARY

6044