

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14405

State File No. _____
Registrar's No. **3617**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE St. Louis St. Louis Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmery		d. STREET ADDRESS (If rural, give location) 5800 Arsenal St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Charles	b. (Middle) Herbert	c. (Last) Bush	4. DATE OF DEATH (Month) (Day) (Year) Apr/ 19 1950
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, married	8. DATE OF BIRTH 9-23-1878	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber	10b. KIND OF BUSINESS OR INDUSTRY Barbering	11. BIRTHPLACE (State or foreign country) Tenn. Nashville	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Martin Bush	13b. MOTHER'S MAIDEN NAME Elizabeth ?	14. NAME OF HUSBAND OR WIFE Bessie Bush
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Nil	17. INFORMANT'S SIGNATURE OR NAME Bessie Bush	ADDRESS 5037 Maple
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic heart disease		
	ANTECEDENT CAUSES Generalized arteriosclerosis Traumatic hemothorax		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year), (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
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22. I hereby certify that I attended the deceased from **3-21-46**, 19__, to **4-19-50**, 19__, that I last saw the deceased alive on **4-19-50**, 19__, and that death occurred at **2:50 PM** from the causes and on the date stated above.

23a. SIGNATURE Palmer Duane Bowdish M.D.	(Degree or title)	23b. ADDRESS 5800 Arsenal St.	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-22-50	24c. NAME OF CEMETERY OR CREMATORY Oak Grove, Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. APR 20 1950	REGISTRAR'S SIGNATURE J. B. Sarsater	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 me

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer.

Signed William J. Salter

Licensed Embalmer No. 4699

P. O. Address W. Salter

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.