

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Paul Busick
State File No. 21269

FILED JUL 6 - 1953
BIRTH NO. 42041 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 609

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ARKANSAS b. COUNTY FULTON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MAMMOTH SPRINGS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 8030	

3. NAME OF DECEASED (Type or Print) a. (First) MARSHA b. (Middle) CHARRISE c. (Last) BAKER	4. DATE OF DEATH (Month) (Day) (Year) JUNE 26, 1953
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, NEVER MARRIED	8. DATE OF BIRTH JUNE 24, 1953	9. AGE (In years last birthday) 0 Months 2 Days
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) * * * *	10b. KIND OF BUSINESS OR INDUSTRY * * * *	11. BIRTHPLACE (State or foreign country) SPRINGFIELD, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME J. W. BAKER	13b. MOTHER'S MAIDEN NAME EARNESTINE CALHOUN	14. NAME OF HUSBAND OR WIFE * * * * *
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS J.W. BAKER, MAMMOTH SPRINGS, ARK.
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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 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Alectasia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature birth DUE TO (c)		
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 checked="" 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) 7625
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Springfield, Greene, Mo.
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22. I hereby certify that I attended the deceased from 6/24/53 to 6/26/53, 1953, that I last saw the deceased alive on June 26, 1953, and that death occurred at 4:30a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul Busick M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 6/27/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6/26/53	24c. NAME OF CEMETERY OR CREMATORY THAYER CEMETERY	24d. LOCATION (City, town, or county) (State) Thayer, Missouri
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DATE REC'D BY LOCAL REG. 6-29-53	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman H. Lohmeyer, Springfield, Mo.
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed William T. Swallow

Licensed Embalmer No. 4816

P. O. Address Springfield

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.