

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2641**
Registrar's No. **0937**

BIRTH NO. FILED FEB 4 1954 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 MO	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY OR TOWN St Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 3 3/4		e. STREET ADDRESS (If rural, give location) 22 318 So JEFFERSON	
d. FULL NAME OF HOSPITAL OR INSTITUTION 318 S. Jefferson		4. DATE OF DEATH (Month) (Day) (Year) JAN 28 54	
3. NAME OF DECEASED (Type or Print) a. (First) EMILY		b. (Middle)	c. (Last) BUSH
5. SEX FEMALE	6. COLOR OR RACE COL	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT. 25/1893
9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months 3	IF UNDER 1 YEAR Days 3	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) L.A.	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME JOHN WILLIAMS	13b. MOTHER'S MAIDEN NAME ALICE	14. NAME OF HUSBAND OR WIFE BEN BUSH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) NO	17. INFORMANT'S SIGNATURE OR NAME BEN BUSH
		ADDRESS 318 S. Jefferson

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia		6 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage DUE TO (c) Hemiplegia		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)
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? 331X

22. I hereby certify that I attended the deceased from **1-24, 1954**, to **1-28, 1954**, that I last saw the deceased alive on **1-26, 1954**, and that death occurred at **9:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Raymond M. Spivy M.D.	(Degree or title)	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 1/28/54
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 2-54	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St Louis County Mo

DATE REC'D BY LOCAL REG. JAN 29 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Walter Watson	ADDRESS 2769 Cherokee
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, ~~or by~~, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.