

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30657**
Registrar's No. **7786**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY Missouri				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3Y5M29da		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"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Chronic Hospital				e. STREET ADDRESS (If rural, give location) 13 5600 Arsenal				212%	
3. NAME OF DECEASED (Type or Print) a. (First) Lucy			b. (Middle) _____			c. (Last) Bush			
4. DATE OF DEATH (Month) (Day) (Year) 9 2 1955			5. SEX female			6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	
8. DATE OF BIRTH 4/25/1868			9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home			11. BIRTHPLACE (City and State or Foreign Country) Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Samuel ?			13b. MOTHER'S MAIDEN NAME Mary ?			14. NAME OF HUSBAND OR WIFE _____			
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. none		17. INFORMANT'S SIGNATURE OR NAME Chronic Hospital, 5600 Arsenal			ADDRESS _____	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Genital Obstructions DUE TO (c) Chronic Bronchitis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH Yes Yes Yes	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 420.1						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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from 3/4 , 19 52 to 9/2 , 19 55 , that I last saw the deceased alive on 9/2 , 19 55 , and that death occurred at 10:05 Am. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) J. Paul Smith M.D.				23b. ADDRESS 5600 Arsenal			23c. DATE SIGNED 9-2-55		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/6/55		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. SEP 6 1955		REGISTRAR'S SIGNATURE J. Paul Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette Ave.				

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

m J.B. (Licensed Embalmer's Statement on Reverse Side)

1236

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.....
Signature of Student Embalmer

Signed.....
Thomas R. Jenewick

Licensed Embalmer No.....*379*

P. O. Address.....*325 Lafayette*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.