

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016516

STATE FILE NUMBER

FILED APR 28 1959

Registration District No.

360

Primary Registration District No.

3076

Registrar's No.

92

300  
1-57 0

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Vernon</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Nevada</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Nevada Hospital</b>		Length of stay in lb <b>Lifetime</b>	d. STREET ADDRESS <b>324 North Clay</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bert Wilburn Bush</b>			4. DATE OF DEATH Month Day Year <b>April 16 1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1880</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days <b>0</b>
IF UNDER 24 HRS. Hours Min. <b>0</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Nevada Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Theodore Douglas Bush</b>		13b. MOTHER'S MAIDEN NAME <b>Sara Logan</b>		14. NAME OF HUSBAND OR WIFE <b>Faye Bush</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Faye Bush 324 North Clay, Nevada, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Hemoplegia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic hypertensive heart disease</b>					<b>2 years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>February 27, 1956</b> to <b>April 16, 1959</b> and last saw <sup>her</sup> <del>him</del> alive on <b>April 15, 1959</b> Death occurred at <b>Nevada, Mo.</b> <b>6:30 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>R. B. Weay, M. D.</i> (Degree or title)			22b. ADDRESS <b>Moore Building, Nevada, Mo.</b>		22c. DATE SIGNED <b>4/17/1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 18, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Antioch Cemetery</b>		23d. LOCATION (City, town, or county) <b>Nevada</b>	(State) <b>Missouri</b>
24. FUNERAL DIRECTOR <b>Ferry Funeral Home Nevada, Missouri</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>4-22-1959</b>	26. REGISTRAR'S SIGNATURE <i>Arma E. Jerry</i>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *B. Douglas Perry* .....

Licensed Embalmer No. *4960* .....

P. O. Address *Wenatchee, Wa* .....

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.