

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020384

STATE FILE NUMBER

FILED JUL 7 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 281

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <i>Boone</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Butler</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Columbia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Poplar Bluff</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Ellis Fishel State Cancer Hosp.</i>		Length of stay in lb <i>28 hrs.</i>	d. STREET ADDRESS (If outside, give location) <i>Rte. 4</i>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Frances</i> Middle <i>Judy</i> Last <i>Busher</i>			4. DATE OF DEATH Month <i>6</i> Day <i>28</i> Year <i>1959</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-10-1907</i>	9. AGE (In years last birthday) <i>52</i> 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) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>Poplar Bluff, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Henry F. Sullivan</i>		13b. MOTHER'S MAIDEN NAME <i>Mary E. Maxwell</i>		14. NAME OF HUSBAND OR WIFE <i>Alfred Busher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <i>Hospital Records</i> Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Congestion - bilateral</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Bilateral pneumonia - generalized</i> DUE TO (c) <i>Sepsis; 2° small bowel obstruction</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>5705</i>					INTERVAL BETWEEN ONSET AND DEATH
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 WORK <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 <i>6-26-59</i> to <i>6-27-59</i> and last saw her alive on <i>6-29-59</i> Death occurred at <i>1:20</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>John V. Redington M.D.</i>			22b. ADDRESS <i>Elleo Zeschel Hosp.</i>		22c. DATE SIGNED <i>6-28-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Reinterred</i>	23b. DATE <i>7-1-1959</i>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <i>Poplar Bluff, Mo</i>	
24. FUNERAL DIRECTOR <i>Lynnan Spradley</i> ADDRESS <i>Columbia, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>June 29, 1959</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. R.E. Palmer</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

The funeral director is responsible for the proper completion of the entire certificate. The attending physician is responsible for the proper completion of the medical certification in the specific manner required by 193.140 MoRS 1949.

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.

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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 embalmed by me, ~~or by~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Lysman Sprinkle*

Licensed Embalmer No. *1013*
P. O. Address *Columbia, Mo*

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.