

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024260

FILED VS JUL 27 1959

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 725

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>50 Yrs</u>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1904 Main St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle Last <u>RUSH</u>			4. DATE OF DEATH Month <u>July</u> Day <u>16,</u> Year <u>1959</u>		
---	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 19, 1893</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	--	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. (3) Switchman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Chicago Great Western</u>	11. BIRTHPLACE (City and state or country) <u>Granite City, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	---	---	---

13a. FATHER'S NAME <u>William Rush</u>	13b. MOTHER'S MAIDEN NAME <u>Agnes Land</u>	14. NAME OF HUSBAND OR WIFE <u>Elizabeth Rush</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Richard L. Rush</u> Address <u>St. Joseph, Mo.</u>
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral vascular accident</u>	<u>9 days</u>
	DUE TO (c) <u>Arteriosclerotic hypertensive cardiovascular disease</u>	<u>years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH But not related to the terminal disease condition given in PART I (a) <u>Dementia, Bronchovascular disease and emphysema</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <u>4-7-58</u> to <u>7-15-59</u> and last saw him alive on <u>7-15-59</u> Death occurred at <u>2:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22. SIGNATURE (Degree or title) <u>Richard L. Maginn MD</u>	22a. ADDRESS <u>Phys. Aug Bldg 216, St. Joseph, Mo</u>	22c. DATE SIGNED <u>7-17-59</u>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 18, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, MO.</u>
--	-----------------------------------	--	---

24. FUNERAL DIRECTOR <u>H.O. Silligaden & Son</u> <u>RR 4.</u>	ADDRESS <u>St Joseph, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>July 17, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Stoddell</u>
--	---------------------------------	--	--

DOCUMENT BY AFFIDAVIT OF R.L. Maginn MD MEDICAL CERTIFICATION

1966
MS OCT 1 100 SA

Dr. Martin

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Robert H. Yaph

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.