RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 6 1959 53

Registration District No. _____ Primary Registration District No. 3010 Registrar's No. 349

59-031678
STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY: CAPE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: CAPE, GIRARDEAU
Length of stay in 1b: 50 YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 530, R, S. FREDERICK
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: CAPE
c. CITY OR TOWN: CAPE, GIRARDEAU
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 530 R, S, FREDERICK
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: BELLE Middle: Last: BUSCH
4. DATE OF DEATH Month 9 Day 22 Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: NEGRO
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1-14-1901
9. AGE (last birthday): 58
IF UNDER 1 YEAR: Months 8 Days 7
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): GREEN BRIER, MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: PETER CATO
13b. MOTHER'S MAIDEN NAME: ODELIA GIBONEY
14. NAME OF HUSBAND OR WIFE: ALBERT E. BUSCH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: KATHRYN BEDELL, Address: CAPE GIRARDEAU, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Metastic adenocarcinoma
DUE TO (c): Adenocarcinoma, right breast
INTERVAL BETWEEN ONSET AND DEATH: about 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 8/11/59 to 9/22/59 and last saw him/her alive on 9/22/59
Death occurred at 4:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Gordon M. Nunnelly, M.D.
22b. ADDRESS: Cape Girardeau, Mo.
22c. DATE SIGNED: 9/28/59

23a. BURIAL, CREMATION, REMOVAL (Specify): ✓
23b. DATE: 9-25-1959
23c. NAME OF CEMETERY OR CREMATORY: SHADY GROVE
23d. LOCATION (City, town, or county) (State): CAPE GIRARDEAU, MO.

24. FUNERAL DIRECTOR ADDRESS: ALVIN DOTSON, SIKESTON, MO.
25. DATE RECD. BY LOCAL REG.: 10-3-1959
26. REGISTRAR'S SIGNATURE: Irene Kasten

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4601

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com
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.