

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 16 1960

60-015191

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2368 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 45 Yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5000 Oak Street			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5000 Oak Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Middle Last Sam E. Busler				4. DATE OF DEATH Month Day Year April 26 1960															
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-28-1890		9. AGE (last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Bus.				10b. KIND OF BUSINESS OR INDUSTRY Insurance Bus.		11. BIRTHPLACE (City and state or country) Pike county Ohio		12. CITIZEN OF WHAT COUNTRY USA											
13a. FATHER'S NAME Lee Busler				13b. MOTHER'S MAIDEN NAME Adila Moats				14. NAME OF HUSBAND OR WIFE Mildred H. Busler											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.#1				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Robert H. Busler 5000 Oak St.													
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>Encephalomalacia due to Central Thrombosis 11 yrs.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Central Emboli</u> DUE TO (c) <u>Thrombophlebitis of iliac Vein</u> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH 11 yrs ago									
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 a.m. p.m. Month, Day, Year		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>Jan 1, 1950</u> to <u>April 26, 1960</u> and last saw him ^{her} alive on <u>April 26, 1960</u> . Death occurred at <u>6 p.m. Kansas City, Mo.</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>Arnold V. Arms M.D.</u>						22b. ADDRESS <u>4635 Wyandotte R. City Mo.</u>				22c. DATE SIGNED <u>4/27/60</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 4-29 60		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery				23d. LOCATION (City, town, or county) (State) Kansas City, Missouri											
24. FUNERAL DIRECTOR ADDRESS Stine & McClure, Kansas City, Mo.						25. DATE RECD. BY LOCAL REG. 4-28-60		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>											

DOCUMENT

MEDICAL CERTIFICATION

ATTEST

BY AFFIDAVIT OF

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 Robert L. Landes, Student Embalmer No. 59

working under my personal supervision

Student Robert L. Landes Signed Joe B. Yoder
Signature of Student Embalmer

Licensed Embalmer No. 417

P. O. Address K.C. Y

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.