WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 33970

Registered No. 29

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PLACE OF DEATH

County Pulaski

Township Liberty or Village or City

Registration District No. 71V

Primary Registration District No. 2941a

(No. St.; Ward)

FULL NAME Anna Bush

PERSONAL AND STATISTICAL PARTICULARS

SEX: Fem

COLOR OR RACE: W

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: 11 (Month) 6 (Day) 1911 (Year)

AGE: 8 yrs. 0 mos. 17 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): ~

BIRTHPLACE (City or town, State or foreign country): Kan.

PARENTS

NAME OF FATHER: John Bush

BIRTHPLACE OF FATHER (City or town, State or foreign country): Okla.

MAIDEN NAME OF MOTHER: Grace Garner

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kan.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace Bush

(ADDRESS) Richland

Filed Nov. 24, 1919. Everett A. Oliver, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 11 (Month) 23 (Day) 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from 11-20, 1919, to 11-23, 1919, that I last saw h~~e~~r alive on 11-23, 1919, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

10 Diphtheria

(Duration) ____ yrs. ____ mos. 3 ds.

Contributory (Secondary) Unknown

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) R E Fowler M. D.

Nov. 23, 1919 (Address) Richland Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals Institutions, Transients, or Recent Residents)

At place of death 8 yrs. ____ mos. 17 ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? Place of death

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Richland Cemetery

DATE OF BURIAL: Nov. 24, 1919

UNDERTAKER: Richland Undertaking ADDRESS: Richland, Mo.

A M Pearcy

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)
o		

DATE OF BIRTH _____ (Month) _____ (Day) 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__. _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h__ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191__
UNDERTAKER	**ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING