MAY 26 1927

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

Do not use this space.

7629

1. PLACE OF DEATH

County: Cole — Registration District No.: 212 — File No.:

Township: Clark — Primary Registration District No.: 5-292 — Registered No.: 8

City: (No. ..... St. ..... Ward)

2. FULL NAME: Amanda Auga Buster

(a) Residence. No. ..... St., ... Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Thomas Buster.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov-30-1864

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
69	3	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

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

(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Miller Co., Mo.

PARENTS

10. NAME OF FATHER: John W. Rush

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

12. MAIDEN NAME OF MOTHER: Eliza Kerry

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky.

14. INFORMANT (Address): Mrs. Flava Buster, Eugene Mo

15. FILED: May 10, 1927 — T. L. Glover, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 17 1927

17. I HEREBY CERTIFY, That I attended deceased from Mar 10, 1927, to Mar 17, 1927, that I last saw her alive on Mar 10, 1927, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis.

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 31

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? ..... DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. T. L. Glover, M. D.

Mar 17, 1927 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Eugene Cemetery

DATE OF BURIAL: Mar 19 1927

20. UNDERTAKER: Schell Mer. Co.

ADDRESS: Eugene Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

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

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1. PLACE OF DEATH
County: Dole
Township: Clark
City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 212
Primary Registration District No. 5292

File No. 8
Registered No. 8

2. FULL NAME: Amanda Anga Buster

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 30 - 1869

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	3	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. Filed April 10, 1927 T. L. Glover
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 17 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., 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.

SUPPLEMENTAL

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

[illegible]

[illegible]

[illegible]

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