

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

Do not use this space.

791

10122

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City..... *St. Louis* (No. *St. John's Hospital*)

File No.....

Registered No. *2703*

St. Ward)

2. FULL NAME

Scott F. Bush

(a) Residence. No. *3711 Evans* St., *11* Ward.

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 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 *Sarah Bush*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 6 - 1881*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 | *8* | *12* | *—* | *—*

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Street car conductor*
(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) *Mo*

10. NAME OF FATHER *Fielding Bush*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Edam Bryan*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

14. INFORMANT *Mrs. Sarah Bush*
(Address) *3711 Evans*

15. FILED *19* 19*27* *May 6* *Starkoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3 - 18 - 1927*

17. I HEREBY CERTIFY, That I attended deceased from *3* *10*, 19*27*, to *3 - 18*, 19*27*. That I last saw ~~deceased~~ alive on *3 - 15*, 19*27*, and that death occurred, on the date stated above, at *10:20 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronch - Pneumonia
1077

CONTRIBUTORY (SECONDARY) *100%* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH..... DATE OF.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *A. G. Lyland*, M. D.
3/19 - 1927 (Address) *3901 Park Ave*

*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 *Calvary* DATE OF BURIAL *3 - 21 1927*
ADDRESS *2039 Wash st*

20. UNDERTAKER *Arthur J. Donnelly*

K. 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.

CONTINUING INFORMATION IS PERMANENT RECORD

602 High...

3901 Park

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