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

Do not use this space.

10529

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Hospital St. ..... Ward)

File No. .....

Registered No. 3148

2. FULL NAME James Bushnell

(a) Residence. No. 112½ N. 6th St., 25 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: Male

4. COLOR OR RACE: White

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: Abt. 60 YEARS | MONTHS: — | DAYS: — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED: Unknown

(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): Unknown

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: H. W. Fath
(Address) Coroner's Office

15. FILED MAR 31 1921, 19..... Max C. Starkeoff, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3/12 1921

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 7-40 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries (Fractured Skull)

Fall to Street

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

CONTRIBUTORY (SECONDARY) 186A 186B

185

(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? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

3/31, 19 (Signed) H. W. Fath, M. D.
(Address) Deputy Coroner

*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: Potters Field

DATE OF BURIAL: 9/31 1921

20. UNDERTAKER: Southern

ADDRESS: 7315 S. Broadway

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.