AUG 17 1927

AUG 1

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

Do not use this space.

22005

1. PLACE OF DEATH
County: Mississippi — Registration District No.: 576
Township: Long Prairie — Primary Registration District No.: 576 2nd
City: ..... (No. ....., ... St. ..... Ward)

File No.: .....
Registered No.: 59

2. FULL NAME: Joseph R. Bush

(a) Residence (Usual place of abode) No. ..... St., ... Ward. ..... (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: M

4. COLOR OR RACE: White

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

5A. ~~(HUSBAND OF~~ (OR) WIFE OF: Rebecca Green Bush

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept. 10-1851

7. AGE: Years 75 | Months 10 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer -
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 20 years
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN): Charleston
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Wm. H. Bush

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

12. MAIDEN NAME OF MOTHER: Ann Russell

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

14. INFORMANT: R. H. Bush
(Address): Bertrand, Mo

15. Filed July 22, 1927. F. B. Vernon, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 16 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 11:50 a. m.:

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suicide by gun shot
Killed self with shot gun

167

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

CONTRIBUTORY (SECONDARY) 170

(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? Suspected
(Signed) Frank S. Hammond, M. D.
7-17. 1927 (Address) Charleston, Mo.

*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: Oak Grove — DATE OF BURIAL: 7/18 1927

20. UNDERTAKER: Hulen Salmon Co. — ADDRESS: Charleston

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