

AUG 18 1927

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

22081

1. PLACE OF DEATH
 County Johnson Registration District No. 629 File No. _____
 Township Progreso Primary Registration District No. 437.9 Registered No. 13
 City Graham No. _____ St. _____ Ward _____

2. FULL NAME William Bush
 (a) Residence. No. Fortworth Texas, 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. 1 mos. 10 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 18 - 18 50

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
77 6 10

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 _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1927

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1927, to July 29, 1927, that I last saw him alive on July 29, 1927, and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of the stomach

440 (duration) don't know mos. _____ ds. _____

CONTRIBUTORY (SECONDARY) don't know
 (duration) _____ yrs. _____ mos. _____ ds. _____

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

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY) _____

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. Fort Worth Tex.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS. Clinical
 (Signed) E. L. Morgan, M. D.
 , 19 (Address) Graham, 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. (See reverse side for additional space.)

14. INFORMANT Mrs Myrtle Davis
 (Address) Graham Mo.

15. FILED 7-29 1927 M. M. Rhoades M.D.
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fort Worth Texas DATE OF BURIAL _____ 19 _____

20. UNDERTAKER X ADDRESS _____ X

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
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wichita
Township Highway
City (No.) St. Ward

Registration District No. 622
Primary Registration District No. 4373

File No.
Registered No. 12
St. Ward

2. FULL NAME

William Bush

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

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)

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 7-29-27 M. M. Rhodes M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 19 27

17. I HEREBY CERTIFY That I attended deceased from in 19....., 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.
..... (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)....., 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 Fort Worth Texas DATE OF BURIAL Sept 19 1927

20. UNDERTAKER Don't know ADDRESS Don't know

SUPPLEMENTARY

REGISTRATION FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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.

S-22081