

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

Do not use this space.

B9309

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1490
 Township Raw Precinct Registration District No. 1002 Registered No. 1490
 City Keokuk (No. General Hospital St. Ward)

2. FULL NAME Mattie Barbara Bush

(a) Residence. No. 900 E. 11th St. 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. 27 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15 1901

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>26</u>	<u>7</u>	<u>7</u>	<u>16</u>	<u>0</u>

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housework
 (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) Maine

10. NAME OF FATHER Leri Stephens

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

12. MAIDEN NAME OF MOTHER Elizabeth Gibbons

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

14. INFORMANT Grover Bush
 (Address) 900 E. 11th

15. FILED 4/2 1928 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 31 1928

17. I HEREBY CERTIFY, that I attended deceased from Deputy Coroner, 1928, to 1928, 1928, and that I last saw him alive on, 1928, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septic Abdomin
140 General Abdominal
129
 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) 146
 (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Herb Cartwright, 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 Edinwood DATE OF BURIAL 4/3/28

20. UNDERTAKER Mrs. C. L. Forster ADDRESS K.C. Mo.

JULY 2 1958

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 1490
 City..... (No. General Hospital) St. Ward.....

2. FULL NAME

Mattie Barbar 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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 4/2 28 19 28 M.M. Carrawe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 31 1928

17. I HEREBY CERTIFY That I attended deceased from
Deputy Coroner 19.....
 that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septic Abortion
General Peritonitis
Self-Induced Abortion

CONTRIBUTORY (SECONDARY)
 (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?

(Signed) W. L. Sprague, M. D.
 , 19 (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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

146

NO FEE WILL BE RECEIVED UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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