

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

Do not use this space.

~~3162~~  
18021

**1. PLACE OF DEATH**

County Jackson  
Township Raw  
City S. E. Mo.

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 2632 Lister St. 14 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-20-29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
6 weeks 14

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work child  
(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) Missouri

**10. NAME OF FATHER**

Earl Bush

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) MO

**12. MAIDEN NAME OF MOTHER**

Lucie Mae Crowe

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Missouri

**14.**

INFORMANT (Address)

Earl Bush  
2632 Lister

**15.**

FILED

5/3 1929 M. M. Crowe  
asst. REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-3 1929

17. I HEREBY CERTIFY, That I attended deceased from 4-17-29, 19\_\_\_\_, to 5-3, 1929, that I last saw him alive on 5-3, 1929, and that death occurred, on the date stated above, at 9:10 a. m.

89A THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
89B

158 Gleet's Media  
Mastitis  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) malnutrition  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH Home

0 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Gram's Stain

(Signed) W. M. Brewer M. D.

5/3 1929 (Address) Mary Hospital

\*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**

Fairplay MO 5-3 1929

**20. UNDERTAKER**

**ADDRESS**

Farestar 15 C Mo

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.

IMMIGRANT RECORD

