

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

Do not use this space.

1. PLACE OF DEATH

County Franklin
Township Washington
City Washington (No.)

Registration District No. 297
Primary Registration District No. 3016

File No. 30970
Registered No. 105
St. Ward)

2. FULL NAME

(a) Residence, No. St. Francis Hospital Ward. Marion, Mo.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 25 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 11 25

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 15 yr.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Francis, Mo.

FATHER 13. NAME Herwan Busse

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Catherine Liphnick

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT By Busse (ADDRESS) Marion, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Harper Cemetery DATE 9-28-1931

19. UNDERTAKER (ADDRESS) W. N. Overstreet

20. FILED Sept 28 1931 O. L. Marshall Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-20-1931

22. I HEREBY CERTIFY, That I attended deceased from 9-8-1931, to 9-20-1931. I last saw him alive on 9-19-1931. Death is said to have occurred on the date stated above, at 7:40 A.M.

The principal cause of death and related causes of importance were as follows:

Septo meningitis 34 79A 34 9/8/31

Other contributory causes of importance: Tertiary Syphilis

Name of operation Cebral Date of to
What test confirmed diagnosis? Cebral Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury S

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify W. N. Overstreet, M. D.

(Signed) W. N. Overstreet (Address) Marion, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

OCT 22 1931

