

WED JUL 12 1938

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

21003
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 379
 (b) Township Kaw Primary Registration District No. 1002
 (c) City K. C. Mo. (d) Street No. St. Mary's Hospital Registered No. 2453 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dennis S. Bush 200
 (a) Residence, No. 1240 Washington St. (If nonresident, give city or town and State)

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 Mrs. Emma Bush

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 1, 1855

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>82</u>	<u>9</u>	<u>17</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio |
 13. NAME Cyrus Bush |
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio |

MOTHER
 15. MAIDEN NAME No Record
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Mrs. Emma Bush
1240 Washington

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington, Ia DATE June 20, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wagner Funeral Home
Kansas City, Mo.

20. FILED June 19, 1938 M. M. Crow
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 18, 1938

22. I HEREBY CERTIFY, That I attended deceased from June 13, 1938 to June 17, 1938
 I last saw him alive on June 17, 1938 Death is said to have occurred on the date stated above, at 8.30 m. A.M
 The principal cause of death and related causes of importance were as follows:

<u>Broncho-Pneumonia</u>	Date of onset
<u>Myocarditis, Chronic</u>	

Other contributory causes of importance:
None

Name of operation None Date of
 What test confirmed diagnosis? None Was there an autopsy Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury
 Where did injury occur? No (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) H. J. Smetone, M. D.
 (Address) 210 Argyle Bldg

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.

Dr. Paul N. Johnstone,
Argyle Bldg.,

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.