

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27147**

Registration District No. **72**

Primary Registration District No. **5-289**

Registrar's No. **67**

1. PLACE OF DEATH:
 (a) County **Clay**
 (b) City or town **Rural Gallatin**
 (c) Name of hospital or institution: **Home**
 (d) Length of stay: In hospital or institution **10 yrs**
 In this community **10 yrs**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Clay**
 (c) City or town **Rural**
 (d) Street No. **# 10 North Kansas City, Mo**
 (e) Citizen of foreign country? **NO**

3. (a) PRINT FULL NAME **W G Rush**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **Wht**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Effie Mae Rush**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **June 2 - 1856**

8. AGE: Years **89** Months **2** Days **13**
 If less than one day _____ hr. _____ min.

9. Birthplace **Penn**
 (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation **Railroad**

11. Industry or business _____

12. Name _____
 13. Birthplace _____
 14. Maiden name **Effie Cecil**
 15. Birthplace **Iowa**

16. (a) Informant **Mr L N. Rush**

(b) Address **2017, Iron, No Kansas City**

17. (a) **Burial** (b) Date thereof **8-17-45**

(c) Place: burial or cremation **Liberty Mo**

18. (a) Signature of funeral director **Martin Federal Home**

(b) Address **North Kansas City, Mo**

19. (a) **Aug 17 - 1945** (b) **Beulah Stetson**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Aug** day **15**
 year **1945** hour **1** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **8-1-45**
 that I last saw him alive on **aug 4**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **8315**
 Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____

23. Signature **J W** (M. D. or other) **M D**
 Address **WKC** Date signed **8-18-45**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1911

RECEIVED

District Health Officer No. 8,

District File No. _____

Date Filed _____ 9-5-42 _____

EMM 7

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..... *John S. Hester*

Licensed Embalmer No. *4349*

P. O. Address..... *W. H. C. Co.*

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Sept

69

Registration District No. 72Primary Registration District No. 5289

Registrar's No.

1. PLACE OF DEATH:

- (a) County Clay
 (b) City or town Rural Gallatin, Tenn
 (If outside city or town limits, write "RURAL" and name of town) (c)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME

W. G. Rush

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased June _____
 _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 89 Months _____ Days _____ If less than one day _____
 _____ hr. _____ min.

9. Birthplace _____
 _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name Unknown
 13. Birthplace Unknown
 _____ (City, town, or county) _____ (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace _____
 _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
 _____ (Burial, cremation, or removal) _____ (Month) (Day) (Year)
 (c) Place: burial or cremation _____

13. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) (Beniah Kitchen)
 _____ (Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April _____
 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
 that I last saw _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

- Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-27147