

Registration District No. 100

Primary Registration District No. 5390

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Dent
(b) City or town rural Springcreek typ
(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 X
In this community a few months
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon
(c) City or town rural
(d) Street No. X
(e) Citizen of foreign country? X
If yes, name country X

3. (a) PRINT FULL NAME

John Calvin Busbey
3. (b) If veteran, name war X 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3
year 1946 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from 6/3/46
that I last saw him alive on 6/3/46
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lou Jane Harper 6. (c) Age of husband or wife if alive X years
7. Birth date of deceased Feb 14 1870
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage
Duration 2 days

8. AGE: Years 76 Months 3 Days 19 If less than one day hr. min. 0

Due to
Due to

9. Birthplace Shannon Co Mo
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation laborer
11. Industry or business lumber

Major findings: Of operations 430
Of autopsy

12. Name John Calvin Busbey
13. Birthplace Mo
14. Maiden name Mary Busbey
15. Birthplace Mo

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?

16. (a) Informant
(b) Address Salem Mo
17. (a) burial (b) Date thereof 6/5/46
(c) Place: burial or cremation Oaksides Cem

While at work? (Specify type of place) (z) Means of injury
23. Signature J. E. Joseph M.D. (M. D. or other) J. M.D.
Address Salem Mo Date signed 6/3/46

18. (a) Signature of funeral director Carl H. Spencer
(b) Address Salem Mo
19. (a) 6-5-46 (b) M. M. Hart M.D. by Miss
(Date received local registrar) (Registrar's signature)

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

33
0

RECEIVED

District Health Officer No. 5,

District File Number 746 396

Date Filed 7-9-46

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, fact should be so stated above.