

FILED DEC 23 1946

Primary Registration District No. 4377

Registrar's No. 180

1. PLACE OF DEATH:

(a) County Nodaway  
(b) City or town Quitman  
(If outside city or town limits, write "RURAL" and name of township)  
(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 all life  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway 74  
(c) City or town Quitman (If outside city or town limits, write "RURAL") 0  
(d) Street No. none (If rural, give location) 0  
(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

John Calvin Busby

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Mollie Busby 6. (c) Age of husband or wife if alive deceased years  
7. Birth date of deceased June 12, 1854  
(Month) (Day) (Year)

8. AGE: Years 92 Months 5 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation retired farmer

11. Industry or business \_\_\_\_\_

12. Name Abraham Busby

13. Birthplace Ohio  
(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 Mrs. Clyde Busby

(b) Address Richmond, Va

17. (a) burial (b) Date thereof 11-23-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
Quitman Cemetery

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Price Funeral Home

(b) Address Marysville, Mo.

19. (a) 11/27/46 (b) Beess Holt  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 20  
year 1946 hour 11 minute 15 P.M.

21. I hereby certify that I attended the deceased from June 25 - 1946 to Nov 20 - 1946  
that I last saw him alive on Nov 20 - 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death congestive heart failure  
Due to arteriosclerosis Duration 8 mo

Due to Chronic myocarditis 20 yrs

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: no operations 930  
Of operations \_\_\_\_\_  
Of autopsy no 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 L. Deane (M: D. or other MD)  
Address Maryville Mo. Date signed 11-21-46

DISTRICT HEALTH OFFICE  
Cambridge, Mass.

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..... *W. M. L. Lee*

Licensed Embalmer No. *2539*

P. O. Address..... *Mariposa, Md.*

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

If this body is not embalmed, fact should be so stated above.