

S. No. 2
OM-8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 19 1947

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 30574
Registrar's No. 320

Registration District No. 47

Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
State Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. 10 mo. 15 days
(Specify whether)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1028 Cherry
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPHINE BUSCH WYATT

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

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced widow

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

7. Birth date of deceased see 25 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8 15
year 1947 hour 8 minute 0 P.M.

21. I hereby certify that I attended the deceased from 23 June
_____, 1947, to 8 Sept, 1947
that I last saw her alive on 8 Sept, 1947
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>8</u>	<u>14</u>	hr. _____ min. _____

Immediate cause of death Ch. Myo Carditis

Due to _____

Due to _____

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

10. Usual occupation None

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

MOTHER FATHER

11. Industry or business _____

12. Name Alvin Busch

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Umbraun

15. Birthplace Umbraun
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant State Hospital Records
(b) Address Fulton, Mo

17. (a) Removal (b) Date thereof Sept. 8, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation London, Kentucky

18. (a) Signature of funeral director Glenn Y. Mangus
(b) Address 712 East St. Fulton, Mo

19. (a) Sept 8-1947 (b) Joel Morosoff
(Date received local registrar) (Registrar's signature)

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 0

23. Signature G.S. Warwick (M. D. or physician)
Address State Hospital No. 1 Date signed 8 Sept 47

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

RECEIVED

District Health Officer No. 9,

District File Number

SEP 17 1947

Date Filed

OCT 28 1947

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.....

Theodore Skinner, Jr, Registered Apprentice No. *55*
working under my personal supervision.

Signed..... *Glen Y. Mansin*

License Embalmer No. *2725*

P. O. Address..... *Fulton, Mo.*

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.