

FILED JUN 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17919

State File No.

BIRTH NO. 124 REG. DIST. NO. 216 PRIMARY REG. DIST. NO. 3061 Registrar's No. 199

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Flat River		c. LENGTH OF STAY (In this place) 0942	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location). 300 Federal St.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)				
a. (First) PEARL	b. (Middle) JANE	c. (Last) DUSH	June 1, 1950				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed <u>2</u>	8. DATE OF BIRTH Oct-20- 1875	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 11	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) /Rochester, Indiana /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Frank Briggs	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE George Dush
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Abe Wright	ADDRESS Esther, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 12h
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary occlusion		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. active & chronic hypertension arterio sclerosis		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		4/20	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 1, 1950, to June 1, 1950, that I last saw the deceased alive on 5-31, 50, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Dr. George V. M.D.	(Degree or title)	23b. ADDRESS Desloge, Missouri	23c. DATE SIGNED 6-2-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June-4-1950	24c. NAME OF CEMETERY OR CREMATORY IOOF St. Francois, Mo	24d. LOCATION (City, town, or county) (State) Flat River, Mo
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DATE REC'D BY LOCAL REG. June 3, 1950	REGISTRAR'S SIGNATURE Esther Rudloff	25. FUNERAL DIRECTOR'S SIGNATURE SPARKS	ADDRESS Flat River, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATE HEALTH OFFICE No. 650-786

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650-786

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.....

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed.....

Murphy Sparks

Licensed Embalmer No. *4236*

P. O. Address *Flat River, 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.