

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH
State File No. 4961

FILED NOV 2 - 1953

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4961</u>			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)					
a. COUNTY <u>Jackson</u>				a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>				c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> <u>3208</u>					
c. LENGTH OF STAY (in this place) <u>3 years</u>				d. STREET ADDRESS (If rural, give location) <u>801 Living</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>M.E. Oates Hosp.</u>									
3. NAME OF DECEASED			4. DATE OF DEATH						
a. (First) <u>Patsy Louise</u>			b. (Middle) <u>Busch</u>			c. (Last) <u>Busch</u>			
(Type or Print)			DATE OF DEATH			<u>10 14 53</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>		8. DATE OF BIRTH <u>12-7-48</u>			
9. AGE (In years last birthday) <u>4 1/2</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>			11. BIRTHPLACE (State or foreign country) <u>Nyssa, Oregon</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13a. FATHER'S NAME <u>James D. Busch</u>		13b. MOTHER'S MAIDEN NAME <u>Atta L. Greenhall</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT'S SIGNATURE OR NAME <u>James D Busch</u>			
18. CAUSE OF DEATH			MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH		
Enter only one cause per line for (a), (b), and (c)			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Septicemia</u>						
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES						
			Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						
			DUE TO (b) <u>Septic Pharyngitis</u>						
			DUE TO (c) _____						
			II. OTHER SIGNIFICANT CONDITIONS						
			Conditions contributing to the death but not related to the disease or condition causing death. <u>Malnutrition</u>				<u>051X</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>10-9</u> , 1953, to <u>Oct 14</u> , 1953, that I last saw the deceased alive on <u>Oct 14</u> , 1953, and that death occurred at <u>5:31 P m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>M. W. Huffman</u> (Degree or title) <u>Dr</u>				23b. ADDRESS <u>5242 St. John - Kansas City Mo</u>				23c. DATE SIGNED <u>10-15-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-17-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mc. Washington</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>			
DATE REC'D BY LOCAL REG. <u>10-16-53</u>		REGISTRAR'S SIGNATURE <u>Steraldine Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Sheib</u> ADDRESS <u>D. C. Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

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 Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address. R. E. Carroll

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.