

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

13762

STATE FILE NUMBER

FILED APR 25 1957

Registration District No. 170 Primary Registration District No. 5630 Registrar's No. 65

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Laclede</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon T. S.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Lebanon</u>		0530 0	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lebanon Rt. 2</u>				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Lebanon Rt. 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Busick</u>						4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1957</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 12 1869 88</u>		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Contractor Retd.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>McClain Co. Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ed Busick</u>				14. MOTHER'S MAIDEN NAME <u>Siss Wagoner</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Ona Flannery Lebanon Mo. Rt. 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u>								INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>794x</u>							
20c. TIME OF INJURY Hour <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a. m. <u>—</u> p. m. <u>—</u>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from <u>June 15, 1951</u> to <u>April 12, 1957</u> and last saw ^{her} him alive on <u>April 11, 1957</u> Death occurred at <u>8.25</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <u>J. H. Johnson</u> (Degree or title) <u>MD</u>					22b. ADDRESS <u>Lebanon Mo</u>			22c. DATE SIGNED <u>4-15-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>4/15/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon</u>			23d. LOCATION (City, town, or county) (State) <u>Lebanon Mo.</u>		
24. FUNERAL DIRECTOR <u>S. P. Palmy Lebanon Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>4-18-1957</u>			26. REGISTRAR'S SIGNATURE <u>Hella L. Ray</u>			

Health, & Welfare
Public
Service

S. 300
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

428
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Received 4-22-57
Laclede County Health Unit
File No. 65
Date Filed 4-22-57

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
Signature of Student Embalmer

Signed S. R. Palmer.....

Licensed Embalmer No. 220

P. O. Address Libanon

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.