

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005821

FILED VS FEB 29 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 215

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b	c. CITY OR TOWN SPRINGFIELD
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CITY HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 504 W. OLIVE
		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EDWARD Middle C. Last BUSH			4. DATE OF DEATH Month FEB. Day 19 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3 JUNE 1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist-Druggist		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Pennsylvania		Months	Days
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Deceased		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist-Druggist		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Deceased		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Hospital Records (Informant was deceased)		Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Blood loss from Colon		7 1/2
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Prod. Carcinoma of Colon	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)	
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20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____	Month, Day, Year	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 SPRINGFIELD, MO.	COUNTY	STATE
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21. I attended the deceased from 2-17-60 to 2-19-60 and last saw ^{her} him alive on 2-19-60	
Death occurred at 4:30 P on the date stated above, and to the best of my knowledge from the causes stated.	

22a. SIGNATURE <i>Joseph N. Pills MD</i>	(Degree or title)	22b. ADDRESS 1715 Boonville SPRINGFIELD, MO.	22c. DATE SIGNED 2/22/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/25/60	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City, town, or county) Springfield, Missouri
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24. FUNERAL DIRECTOR Klingner Mortuary	ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 2-26-60	26. REGISTRAR'S SIGNATURE <i>Effie E. Melton</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Glenn D Williams

Licensed Embalmer No. 4651

P. O. Address Springfield

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.