

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-019045
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 387

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1 0109				
2 6001				
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4 1				
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7 1				
8 1				
9 527.1				
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11				
12 2-0				
13 3-0				
	SHOULD READ	BY AFFIDAVIT OF		

FILED JUN 6 1963	
1. PLACE OF DEATH a. COUNTY <u>BOONE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>COLUMBIA</u> Length of stay in 1b <u>3 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MISSOURI MEDICAL CENTER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u> c. CITY OR TOWN <u>EXCELSIOR SPRINGS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First <u>MAXINE</u> Middle <u>BUSH</u> Last <u>BUSH</u> 4. DATE OF DEATH <u>JUNE 2, 1963</u>	5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH <u>NOV 21, 1915</u> 9. AGE (last birthday) <u>47</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) <u>MISTIC, IOWA</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	13a. FATHER'S NAME <u>DAVID WALTERS</u> 13b. MOTHER'S MAIDEN NAME <u>ADA INMAN</u> 14. NAME OF HUSBAND OR WIFE <u>HERBERT BUSH</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Address <u>UNIVERSITY OF MISSOURI MEDICAL RECORDS</u>	18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Embolism</u> 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) _____ 20c. TIME OF INJURY Hour _____ a.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 _____ COUNTY _____ STATE _____
21. I attended the deceased from <u>5-31-63</u> to <u>6-2-63</u> and last saw him alive on <u>6-2-63</u> Death occurred at <u>1:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Heland U. P. Palmer</u> 22b. ADDRESS <u>unmc, Columbia mo</u> 22c. DATE SIGNED <u>6-2-63</u>	23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 23b. DATE <u>6/2/63</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Elmira Cem.</u> 23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Pridchard Funeral Home, Excelsior Springs</u>	25. DATE RECD. BY LOCAL REG. <u>June 2 1962</u> 26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>

USE BLACK INK OR TYPEWRITER RIBBON

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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 *Leidell Fairman*

Licensed Embalmer No. 44589

P. O. Address *Excelsior Springs, Mo.*

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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.