

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

6881

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. **1963**
 City *St. Louis, Mo.* (No. *3400 Russell Ave*) St. Ward)

2. FULL NAME

(a) Residence. No. *3625 Castleman Ave* St. *17* Ward.
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Augusta Kraft Buchler*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 4 - 1857*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 5 22

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Vice President*
 (b) General nature of industry, business, or establishment in which employed (or employer) *Atlas Leather Co*
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis, Mo.*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Unknown Buchler*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Unknown*
 (STATE OR COUNTRY) *31*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown*
 (STATE OR COUNTRY)

14. INFORMANT *Augusta Buchler*
 (Address) *3625 Castleman Ave*

15. FILED: *29 1932* REGISTRAR *W. E. Starnes*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 26 1932*

17. I HEREBY CERTIFY, That I attended deceased from *2-26-1932* to *2-26-1932*
 that I last saw h. / m. alive on *Feb 26 - 1932* and that death occurred, on the date stated above, at *10:37 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocarditis
9:30
9:30 (duration) yrs. mos. ds.

CONTRIBUTORY *Chr. Myocarditis*
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *930*
 IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH. *No* DATE OF

20. WHAT TEST CONFIRMED DIAGNOSIS? *No*

(Signed) *Dr. E. Hein* M. D.
27 1932 (Address) *317 N. Eleventh*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *San Lee Burial Park* DATE OF BURIAL *Feb 29 1932*

20. UNDERTAKER *Wm. J. Robert* ADDRESS *1905 1/2 Grand Blvd*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

