

REC'D JUL 12 1938

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

20732
Do not use this space.

791
1003

5871

1. PLACE OF DEATH

(a) County St. Louis Mo. Registration District No. 1
(b) Township _____ Primary Registration District No. _____ Registered No. _____
(c) City St. Louis Mo. (d) Street No. City Hospital # 2 St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jetus Buehler

(a) Residence, No. 2825A Sheridan St. 21 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED nil
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6/18/38

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 DAY, HRS. OR MIN.
3 Months nil

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil
9. Industry or business in which work was done, as saw mill, bank, etc. ✓
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

FATHER 13. NAME Willie Buehler 0

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss 1

MOTHER 15. MAIDEN NAME Unknown 1

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss

17. INFORMANT Clarence Yates - P.D.
(ADDRESS) 4609 50th St

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington U. DATE 7-22-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. R. Buckley 530 Putzger
Cherolmen 2nd St

20. FILED JUN 29 1938 J. D. Buckley
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/18 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 6:45 PM m.
The principal cause of death and related causes of importance were as follows:

Steel Bow
Spontaneous abortion
Date of onset _____
Other contributory causes of importance:
Cause and manner could not be determined

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury See above
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Joseph M. Quinn M.D.
(Address) Deputy Coroner

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.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

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

Do not use this space.

N. 2.—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 very important.

SUPPLEMENTARY

1. PLACE OF DEATH
 County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **5871**
 (c) City **St. Louis Mo** (d) Street No. **2825² SHERIDAN** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **FORTUS BUCHTER**
 (a) Residence, No. **28259 Sheridan** St. **21** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **unk** 4. COLOR OR RACE **Black** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **mt.**
 (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **6-18-38**

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

FATHER'S NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

MOTHER'S NAME
 15. MAIDEN NAME **JOSEPHINE CLAYTON**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **MISS.**

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (NAME) (ADDRESS).....

20. FILED **7/19** 19**38** **J. B. Rudeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **6-18-38**
 22. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....
 I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify..... (Signed)....., M. D.
 (Address).....

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Licensed Embalmer's Statement on Reverse Side)

5-20732

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.