

S. No. 2
11-10-39
5-17-39
1-X21492

SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27295

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7191**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Deaconess Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **one month**
(Specify whether years, months or days)

In this community **Birth**
years, months or days

3. (a) PRINT FULL NAME **Herman P. Buss** *201*

8. (b) If veteran, name war **None**

3. (c) Social Security No. **492-09-8831**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Laura**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **September 25, 1886**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
53	11	0	hr. _____ min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Manager**

11. Industry or business **Midwest Sheet Metal Div.**

MOTHER FATHER

12. Name **Carl A Buss**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Laura K. Buss**

(b) Address **4247 Lexington Ave**

17. (a) **Burial** (b) Date thereof **8/28/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cemetery**

18. (a) Signature of funeral director **Math Hermann & Son**

(b) Address **2161 East Fair Ave**

19. (a) **AUG 24 1940** (b) *J. J. Bruck*
(Date of death) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **0 Missouri** (b) County _____

(c) City or town **St. Louis** *10*
(If outside city or town limits, write "RURAL")

(d) Street No. **4247 Lexington Ave**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **25th**
year **1940** hour **8:55 AM** minute _____ M.

21. I hereby certify that I attended the deceased from **Aug 1st**
1940, to **Aug 25th**, 1940;
that I last saw him alive on **Aug 25th**, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Hepatic Disease

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)

(e) Means of injury _____

23. Signature *L. W. Kampen* (M. D. or other) _____

Address **203 Bowman St** Date signed **8/26/40**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 William G. Buchholz

Licensed Embalmer No. 2110

P. O. Address St. Louis Mo

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.