

NOV 16 1940

District No. **791** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 Days**
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Emily Busse**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Raymond** 6. (c) Age of husband or wife if alive **35** years

7. Birth date of deceased **June 16 1903**
(Month) (Day) (Year)

8. AGE: Years **37** Months **4** Days **6** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **George Brown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Raymond Busse**

(b) Address **2831 Lafayette**

17. (a) **Burial** (b) Date thereof **10/25/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **OCT 23 1940** (b) **J. J. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **23**
(If outside city or town limits, write "RURAL")
(d) Street No. **2831 Lafayette**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **22**,
year **1950** hour **7:20** minute _____ P. M.

21. I hereby certify that I attended the deceased from **October 14**, 19 **40**,
that I last saw h **er** alive on **October 22**, 19 **40**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion** Duration **2 weeks**
Due to **Arteriosclerosis, Unilateral Stenosis** **10 yrs.**

Due to **Rheumatic Heart Disease** **10 yrs.**

Other conditions **Old left Hemiplegia** **1 yr.**
(Include pregnancy within 3 months of death)

Major findings: Of operations **A. B.**

Of autopsy **As above**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (c) Means of injury _____

23. Signature **W. S. Hawken, M.D.** (M. D. or other) **10/23/40**
Address **1515 Lafayette Ave.** Date signed _____

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.....

Guy W. Wilkinson

Licensed Embalmer No.....

3575

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, fact should be so stated above.