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FILED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9150

State File No.

Registration District No. **791**

Primary Registration District No. **1003**

Registar's No. **2560**

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

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:
Alexian Bros. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULLNAME **Cyrus Buster**
3. (b) If veteran, name war **Unknown**
3. (c) Social Security No. _____

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

6. (b) Name of husband or wife **Essie**
6. (c) Age of husband or wife if alive **1888** years

7. Birth date of deceased: **Jan. 6 1888**
(Month) (Day) (Year)

8. AGE: Years **53** Months **2** Days **15**
If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name **Bernard Buster**

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

14. Maiden name **Mary Avis**

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

16. (a) Informant **Mrs. Essie Buster**

(b) Address **Hematite, Mo.**

17. (a) **Removal** (b) Date thereof **3/22/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hematite, Mo.**

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

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

19. (a) **APR 21 1941** (b) **J. Bredbeck**
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **50**
(c) City or town **Hematite**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **20**
year **1941** hour **6:45** minute _____ P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Burns of 1st 2nd 3rd 4th degree on back, chest, abdomen, both buttocks, flexor surface of both thighs, both legs and feet, both wrists and hands, neck and scalp. Suffered in a burning condition at Festus Mo.
(Include pregnancy within 3 months of death)

Underline the cause to which death should be charged statistically.
Major findings:
Damage of Property Could not be determined
Of autopsy _____

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

(a) Accient, suicide, or homicide (specify) **Open Verdict**

(b) Date of occurrence **3/20/41**

(c) Where did injury occur? **Festus Mo**
(City or town) (County) (State)

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

Will he at work? _____ (Specify type of place)
(e) Means of injury **9**

23. Signature **Thomas J. Callahan** (Doctor or other)
Address **Deputy Coroner** Date signed **3/23/41**

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..... *Albert G. Hoppe*.....

Licensed Embalmer No. 2971

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9100

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2560

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Unknown

(c) City or town Unknown
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown
(If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lynus Buster

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>53</u>	<u>2</u>	<u>15</u>	_____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation Lab.

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 7-29-41 (b) J. J. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 20
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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? Restroom Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Thos J. Bellman (M. D. or other) _____
Address Deputy Coroner Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

