

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 28 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39598

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 11267

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST LOUIS.
(c) Name of hospital or institution: Lutheran Altman 54 yrs +
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 178
(c) City or town ST LOUIS.
(d) Street No. 8721 HALLS FERRY ROAD
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LAURA BUSER
(b) If veteran, name war _____ (c) Social Security No. 0

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December 16
year 1943 hour 2 minute 4 A.M.
21. I hereby certify that I attended the deceased from Sept 15
1943 to 12-16 1943
that I last saw her alive on 12-15 1943
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JUNE 6 1862
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis Duration 5 yrs?
Due to Arteriosclerosis
Due to _____
Other conditions Senile dementia 1 yr. 9
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
81 6 10 hr. _____ min.
9. Birthplace ST LOUIS _____
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation nil
11. Industry or business _____
12. Name IGNATZ BUSER
13. Birthplace GERMANY _____
14. Maiden name CAROLINA WESTERMAN
15. Birthplace GERMANY _____
(City, town, or county) (State or foreign country)

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? _____
(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 Eugene P. Arnold (M. D. or other) MD.
Address 1449 McCaran Date signed 12/16/43

16. (a) Informant C. Shuman
(b) Address 8721 Halls Ferry Rd
17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bellfontaine
18. (a) Signature of funeral director B. Berme...
(b) Address 1936 St Louis
19. (a) DEC 17 1943 J. J. Predeck
(Date received local registrar) (Registrar's signature)

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. 506
working under my personal supervision.

Signed Theo D. Bidemiedm

Licensed Embalmer No. 506

P. O. Address 1936 17 Louis Ave.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 11267

Registration District No. 318 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
(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) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Laura Buser

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased June 6 (Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days _____ If less than one day, min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JAN 4 1944 (b) J. J. Bredich
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ Minute _____ M.

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

Duration

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

5-39598