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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 13 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4942

Registration District No. 318

Primary Registration District No. 1003

State File No. ....

Registrar's No. 2218

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:  
St. Louis Children's 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 FULL NAME ALFRED EUGENE BUHS

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M. 5. Color or race W.H.

6. (a) Single, widowed, married, divorced — 0

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased DEC. 26 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

2 8 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name ANDREW J. BUHS

13. Birthplace ILLMO MD. O  
(City, town, or county) (State or foreign country)

14. Maiden name PHILOMENE DIEBOLD

15. Birthplace ILLMO MD. O  
(City, town, or county) (State or foreign country)

16. (a) Informant ANDREW J. BUHS

(b) Address 7709 LEMBURG DR.

17. (a) BURIAL (b) Date thereof MAR. 7. 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW SS. PETER & PAUL

18. (a) Signature of funeral director M.V. CROGHAN

(b) Address 7146 MANCHESTER RD.

19. (a) WAP 6 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis

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

(d) Street No. 7709 LEMBURG DRIVE  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month march day fifth  
year 1944 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from 3-4-44, 1944, to 3-5, 1944;  
that I last saw h. him alive on 3-5-, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acidosis  
Atelactasis (L.L.)  
unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration 3 days

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Atelactasis L.L.

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 0

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address [Signature] 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.....

*J. 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4842

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2218

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)

3. (a) PRINT FULL NAME Alfred E. Bueh  
 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 S

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

7. Birth date of deceased Dec 26 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days 55  
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.....

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 (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) MAR 27 1944  
(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 Mar Day 27 Year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
 that I last 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)

PHYSICIAN

Major findings:  
 Of operations.....

Of autopsy.....

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?  
(Specify type of place)

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

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

Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

