

S. No. 2
M-5-43
5-17-39
1 X36671

STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. 31207
Registrar's No. 149

Registration District No. 310 Primary Registration District No. 3058

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

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(c) Name of hospital or institution: St. Joseph Hospital
(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 St. Charles
(c) City or town St. Charles
(d) Street No. 1007 Howell
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Infant Wayne Robert Buse
(b) If veteran, name war NIL
(c) Social Security No. NIL

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 7 1946

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u> hr. _____ min.

9. Birthplace St. Charles Missouri
10. Usual occupation None

MOTHER FATHER
11. Industry or business _____
12. Name Robert J. Buse
13. Birthplace St. Charles Missouri
14. Maiden name Kathleen L. Schneider
15. Birthplace O'Fallon Missouri

16. (a) Informant Robert J. Buse
(b) Address 1007 Howell St. Charles, Mo.
17. (a) burial (b) Date thereof Sept 8, 1946
(c) Place: burial or cremation St. Peters Cemetery St. Charles, Mo.
18. (a) Signature of funeral director H. C. Dallmeyer & Sons Co.
(b) Address 800 N. 2nd St. Charles, Mo.
19. (a) Sept 10-46 (b) Frankie Hammett

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 7 year 1946 hour 11 minute 30
21. I hereby certify that I attended the deceased from Sept 7 1946 to Sept 7 1946
that I last saw him alive on Sept 7 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral
probable obstruction
placental circulation
maternal
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy 160

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? _____
Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 9-9-46

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED
District Health Officer No. 9,
District File Number ~~9-46-123~~
Date Filed ~~9-16-46~~

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..... *Joseph I Landolt*
Licensed Embalmer No..... *4189*
P. O. Address..... *St. Louis*

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.