S. No. 2
OM—2-43
v. 5-17-39
P I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 24 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11899

Registration District No. _____ Primary Registration District No. 6076 Registrar's No. 41

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Eldorado Park
(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 years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis
(c) City or town Eldorado Park
(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 _____

3. (a) PRINT FULL NAME JOHN G BUCHER
3. (b) If veteran, name war NO
3. (c) Social Security No. none
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July (Month) 18 (Day) 1877 (Year)
8. AGE: Years 75 Months 8 Days 0 If less than one day _____ hr. _____ min.
9. Birthplace St Louis (City, town, or county) MO (State or foreign country)
10. Usual occupation Retired
11. Industry or business DK
MOTHER
12. Name DK
13. Birthplace DK (City, town, or county) (State or foreign country)
FATHER
14. Maiden name DK
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Estelle M. Bucher
(b) Address 4308 Penrose
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-47 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem
18. (a) Signature of funeral director Cullenane Bros
(b) Address 3320 N. Kingshighway
19. (a) 3-20-47 (Date received local registrar) (b) Ruth Allen MD (Registrar's signature) MSW

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18 year 1947 hour 9 minute 30 A. 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 — Duration
Cause unknown
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Ruth L Allen (M. D. or other)
Address Actg. Comm. of Health Date signed 3-20-47

(Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmed.

Signed Fred Frick

Licensed Embalmer No. 3186

P. O. Address St. Louis Mo.

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.