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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

3459
State File No. _____
Registrar's No. 216

Registration District No. 377

Primary Registration District No. 6576

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Overland, Rt. 7 Box 747-A /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 23 Years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Louis C. Buschard
3. (b) If veteran, name war _____
3. (c) Social Security No. 49720-3887

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Estella
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Dec. 22 1881
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 9
If less than one day hr. min.

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

10. Usual occupation Maintenance Man

11. Industry or business Private Industry

12. Name Peter Buschard

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

14. Maiden name Sophia Junge

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

16. (a) Informant Lewis Buschard

(b) Address Overland Rt. 7 Box 747-A

17. (a) Burial (b) Date thereof 2/4/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem Luth Cem

18. (a) Signature of funeral director Berman Bros. Inc

(b) Address 2504 Wagon Rd Overland Mo

19. (a) 2-3-48 (b) Overland
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis 9/
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Overland Rt. 7 Box 747-A
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1
year 1948 hour 7 minute 00 A.M.

21. I hereby certify that I attended the deceased from
1938 to Oct 1947
that I last saw him alive on 18 Oct 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Due to Arteriosclerosis of the heart disease
Due to _____

Duration
hours

years

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 _____

Signature Paul H. Whitener (M. D. or other) M.D.

Address 8173 Myrtle Ave Date signed Feb 4 1948

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

MOTHER FATHER

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 Oscar F Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 1x 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.