

DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **113920**
Registrar's No. **4215**

FILED MAY 11 1948

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 ST. LOUIS

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ALEXIAN BROS.
(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 _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 3826 GRAVOIS AV.
16 (If rural, give location)

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

If yes, name country _____

3: (a) PRINT FULL NAME HARRY P. Buchrucker

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 M

6. (b) Name of husband or wife ANNA M. Buchrucker alive _____ years

6. (c) Age of husband or wife if _____ years

7. Birth date of deceased MAY 18 1882
(Month) (Day) (Year)

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

65 11 14 _____ hr. _____ min.

9. Birthplace CITY IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation FLORIST

11. Industry or business OWNER

MOTHER FATHER

12. Name FRED C. Buchrucker

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

14. Maiden name EMMA MASNIER

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

16. (a) Informant Mrs Anna M. Buchrucker

(b) Address 3826 Gravois Av.

17. (a) BURIAL (b) Date thereof MAY 5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SUN SET BURIAL PK

18. (a) Signature of funeral director E. J. Schuur

(b) Address 3125 Lafayette Av.

19. (a) MAY 4 1948 (Date received local registration)

J. P. Brennan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1948 hour 1 minute 45 p.M.

21. I hereby certify that I attended the deceased from April 21, 1948, to May 2, 1948, that I last saw him alive on May 2, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 6 days

Due to Chv Myocarditis 1 yr.

Due to arteriosclerosis ?

Other conditions None

(Include pregnancy within 3 months of death)

Major findings: None

Of operations None

Of autopsy None

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 industry)

Means of injury _____

23. Signature Max Stankoff (M. D. or other) MD

Address 512 Dow Rd Date signed 5/11/48

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 Vallone

Licensed Embalmer No

4014

P. O. Address

3125 Perry 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.**