

FILED MAR 8 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4472

State File No. \_\_\_\_\_

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>117</u>   |   | PRIMARY REG.-DIST. NO. <u>5436</u>   |  | Registrar's No. <u>4</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Gasconade</u>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u> |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Boulware Twp</u>   |  |   |   | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Boulware Twp.</u>                                     |  |  |  |
| c. LENGTH OF STAY (in this place) <u>80 yrs</u>  |  |   |   |  |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3 mi. N. W. of Bay</u>  |  |   |   | d. STREET ADDRESS (If rural, give location) <u>near Bay, Missouri</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or Print)  |  | a. (First) <u>LOUISE</u>  |   | b. (Middle) <u>WILHELMINE</u>  |  | c. (Last) <u>BUSCHMANN</u>   |  |
| 4. DATE OF DEATH   |  | (Month) <u>Feb</u>  |   | (Day) <u>26</u>  |  | (Year) <u>1949</u>   |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>  |  | 8. DATE OF BIRTH <u>Jan-28-1869</u>  |  |
| 9. AGE (In years last birthday) <u>80</u>  |  | IF UNDER 1 YEAR Months _____ Days _____   |   | IF UNDER 4 HRS. Hours _____ Min. _____   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY _____ |  |  | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u>                        |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u>   |  | 13a. FATHER'S NAME <u>Henry Linnemann</u>   |   | 13b. MOTHER'S MAIDEN NAME <u>Charlotte Meyer</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>Henry Buschmann</u>                               |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>   |   | 17. INFORMANT'S SIGNATURE OR NAME <u>Louis Buschmann</u> ADDRESS <u>Bay, Mo</u>  |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.                 |  | MEDICAL CERTIFICATION   |   |  |  |  |  |
|  |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>                                  |  |
|  |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Hypertension</u> |   |  |  |  |  |
|  |  | DUE TO (c) <u>Chronic Pyelitis</u>  |   |  |  |  |  |
|  |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                     |   |  |  |  |  |
| 19a. DATE OF OPERATION <u>Jan 22</u>   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____  |   | 21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____  |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21f. HOW DID INJURY OCCUR? _____   |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>2-26, 1949</u> , to <u>2-26, 1949</u> , that I last saw the deceased alive on <u>2-25, 1949</u> , and that death occurred at _____ m., from the causes and on the date stated above. |  |   |   |  |  |  |  |
| 23a. SIGNATURE (Degree or title) <u>Charles G. Schmidt M.D.</u>  |  |   |   | 23b. ADDRESS <u>Gerald, Mo</u>   |  | 23c. DATE SIGNED <u>2-26-49</u>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 24b. DATE <u>2-28-49</u>  |   | 24c. NAME OF CEMETERY OR CREMATORY <u>Bay Zion Cemetery</u>  |  | 24d. LOCATION (City, town, or county) (State) <u>Bay, Mo</u>                     |  |
| DATE REC'D BY LOCAL REG. <u>2-28-49</u>  |  | REGISTRAR'S SIGNATURE <u>P. G. Mandeville</u>   |   | FUNDRAISING DIRECTOR'S SIGNATURE <u>August Hermann</u>   |  | ADDRESS <u>Hermann, Mo</u>   |  |

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

37  
0  
0

RECEIVED  
District Office No. 9  
Date: 3-7-49  
Dr.

**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 \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

Student .....  
Student Embalmer

Signed *August Bleumer*  
Licensed Embalmer No. 3160

P. O. Address Hermann, 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.