

FILED JUL 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20845
State File No. 5841
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri b. COUNTY St. Louis	
c. LENGTH OF STAY (In this place) 3 Weeks		c. CITY (If outside corporate limits, write RURAL and give township) Arbor Terrace	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If rural, give location) 3720 Lawler Drive	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Rosalie	b. (Middle) A.	c. (Last) Buscher	(Month) July (Day) 4 (Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 5, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 74 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 4 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) Holstein Missouri		12. CITIZEN OF WHAT COUNTRY? U.S. A.	

13a. FATHER'S NAME Henry Huenefeld	13b. MOTHER'S MAIDEN NAME Mathilda Dothage	14. NAME OF HUSBAND OR WIFE Albert Buscher
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Albert Buscher	ADDRESS 3720 Lawler Drive
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardia - Chr.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio-renal disease DUE TO (c) -		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 1310
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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? 4th floor
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22. I hereby certify that I attended the deceased from 6-12, 1949, to 7-4, 1949, that I last saw the deceased alive on 7-4, 1949, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE Laymond C. Sunderman M.D.	(Degree or title)	23b. ADDRESS 4945 Nat'l Bridge	23c. DATE SIGNED 7/5/49
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24a. BURIAL, CREMATION (Specify) Removal Via Motor	24b. DATE 7-6-49	24c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery	24d. LOCATION (City, town, or county) (State) Holstein, Missouri
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DATE REC'D BY LOCAL REG. JUL 5 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Math. Hermann & Son, Inc.	ADDRESS 2161 E. Fair Ave
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Student Embalmer No. _____

Signed W. H. H. H. H.

Licensed Embalmer No. 375

P. O. Address H. H. H. H.

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.