

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6041

State File No. ....

318

1003

Registrar's No. 1738

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> )		c. LENGTH OF STAY (in this place) <b>34 yrs</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5049 Claxton Ave.</b>				e. STREET ADDRESS (If rural, give location) <b>5049 Claxton Avenue</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Emil</b>		b. (Middle) _____		c. (Last) <b>Buenemann</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>2 - 23 - 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2 - 24 - 1885</b>		9. AGE (in years last birthday) <b>69</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 MRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Lincoln County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Fred Buenemann</b>		13b. MOTHER'S MAIDEN NAME <b>Sophia Buenemann</b>		14. NAME OF HUSBAND OR WIFE <b>Emily Buenemann</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>497-03-2772</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Emily Buenemann, 5049 Claxton</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic heart disease</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>→</b>	
19a. DATE OF OPERATION _____		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4200</b>			
22. I hereby certify that I attended the deceased from <b>Sept 5, 1953 to Feb 23, 1955</b> , that I last saw the deceased alive on <b>Feb 22, 1955</b> , and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Oliver G. McJannet M.D.</b>				23b. ADDRESS <b>Fort Thekla As Home</b>		23c. DATE SIGNED <b>2/23/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>2/25/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>		
DATE REC'D BY LOCAL REG. <b>FEB 23 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Drehmann-Harral 1905 Union Blvd.</b>			

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

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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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed... *Warren A. Carver* .....

Licensed Embalmer No. *35* .....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.