

STANDARD CERTIFICATE OF DEATH

13165
State File No.
Registrar's No. 3240

FILED APR 28 1955

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) a. STATE Missouri b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN St. Louis	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 Jewish Hospital			STREET ADDRESS (If rural, give location) 12 4946 McPherson		
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) Herman	c. (Last) Buchholz	4. DATE OF DEATH (Month) (Day) (Year) April 9, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 3, 1883	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Modeler		10b. KIND OF BUSINESS OR INDUSTRY Plaster	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Augusta Unknown	14. NAME OF HUSBAND OR WIFE May		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 496-14-7370A	17. INFORMANT'S SIGNATURE OR NAME May Buchholz, 4946 McPherson		ADDRESS _____	
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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lung			INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
	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. atrophic gastritis			weeks	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 163x			
22. I hereby certify that I attended the deceased from 7/31, 1948 , to 4/9, 1955 , that I last saw the deceased alive on 4/9, 1955 , and that death occurred at 11:35p m. , from the causes and on the date stated above.					
23a. SIGNATURE Max J. Franklin M.D. (Degree or title)			23b. ADDRESS 634 N. Grand		23c. DATE SIGNED 4/11/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-13-55	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
DATE REC'D BY LOCAL REG. APR 11 1955	REGISTRAR'S SIGNATURE Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.		

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

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 365
P. O. Address St. Louis

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.

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