

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

385883

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 547

Registrar's No. 2486

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Ann</b> 4071 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b> Length of stay in lb <b>1 week</b>		d. STREET ADDRESS (If outside, give location) <b>3425 St. William Lane</b> Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Warren D. Buell</b>			4. DATE OF DEATH Month Day Year <b>Oct. 6, 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1899</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Air Force</b>	9c. BIRTHPLACE (City and state or country) <b>Kansas</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Air Force</b>	10c. BIRTHPLACE (City and state or country) <b>Kansas</b>
11. BIRTHPLACE (City and state or country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dexter O. Buell</b>		14. MOTHER'S MAIDEN NAME <b>Lena Hansen</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>489-09-1841</b>	
17. INFORMANT <b>Dorothy Buell</b> Address <b>3405 St. William Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post operative hepatic failure</b> DUE TO (b) <b>Cirrhosis of liver</b> DUE TO (c) <b>5810</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>Cardiovascular hypertensive disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>7-19-57</b> to <b>10-6-57</b> and last saw <b>him</b> alive on <b>10-6-57</b> . Death occurred at <b>11 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>W. F. Melick MD</b> (Degree or title)		22b. ADDRESS <b>3720 Washington</b>	
22c. DATE SIGNED <b>10-7-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Oct. 9, 1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>Schumacher's</b> ADDRESS <b>3013 Meramec St.</b>		25. DATE RECD. BY LOCAL REG. <b>10-8-57</b>	
26. REGISTRAR'S SIGNATURE <b>Herbert P. Donke MD</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

S. 300  
v. 1-56Health,  
& Welfare  
S. Public  
h Service

Wm. MELICK  
BEAUMONT BLDG.

Je. 5-6396

3-6 P.M.

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 *Jack Haupt*

Licensed Embalmer No. 47

P. O. Address *St. Paul*

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.