Health, Welfare Public Service

300 -57

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI 504:5-57

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2712

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 880

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS. Inside Limits Yes ☒ No ☐	c. CITY OR TOWN ST. LOUIS Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 22 ST. ANTHONY Length of stay in 1b 3 DAYS	d. STREET ADDRESS (If outside, give location) 2/6 to 3441 HUMPHREY Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First CAROL Middle ANN Last BUDDY

4. DATE OF DEATH Month Day Year 1-23-1958

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 7-15-1957 9. AGE (In years last birthday) — IF UNDER 1 YEAR Months 6 Days 8 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 10b. KIND OF BUSINESS OR INDUSTRY NONE 11. BIRTHPLACE (City and state or country) ST. LOUIS. MO 12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME CHARLES. F. BUDDE Jr. 13b. MOTHER'S MAIDEN NAME JEAN. McDONALD. 14. NAME OF HUSBAND OR WIFE NONE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. NONE 17. INFORMANT Charles F Budde Address 3441 Humphrey.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Viral pneumonitis — 6 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Laryngeal spasm — 6 days

DUE TO (c) Atelectasis of left lung. — 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 492x

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 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 1-19-58, to 1-23-58 and last saw her alive on 1-23-58

Death occurred at 7:45 AM p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John D Sevil M.D. 22b. ADDRESS 3739 Morris 22c. DATE SIGNED 1-24-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremated 23b. DATE 1-25-1958 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery 23d. LOCATION (City, town, or county) (State) Lemay 23 Mo.

24. FUNERAL DIRECTOR Ringbommelle. ADDRESS 3819 So Grand. Blvd. 25. DATE RECD. BY LOCAL REG. JAN 24 '58 26. REGISTRAR'S SIGNATURE Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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. .....

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.