

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033404

STATE FILE NUMBER

FILED OCT 6 1958 Registration District No. 179 Primary Registration District No. 4288 Registrar's No. 174

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| 1. PLACE OF DEATH a. COUNTY <u>Lincoln</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>170</u> b. COUNTY <u>St Louis</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOSCOW MILLS</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>2009 St Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wells Nursing Home</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN HENRY BUESCHER</u> | | | 4. DATE OF DEATH Month Day Year <u>Sept 19 1958</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr 21-1870</u> | | 9. AGE (In years last birthday) <u>88</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORK ON FURNACES</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FURNACE</u> | 11. BIRTHPLACE (City and state or county) <u>Cappeln Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>Casper Buescher</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARY ?</u> | | 14. NAME OF HUSBAND OR WIFE <u>Elizabeth Buescher</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>491167491</u> | | 17. INFORMANT Address <u>J.W. Ruhl Weitzville Mo</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>331X</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u> <u>UNKNOWN</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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 <u>JAN 1957</u> to <u>SEPT 1958</u> and last saw ^{per him} alive on <u>SEPT 10, 1958</u> Death occurred on <u>10 00</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Paul T. Berry MD</u> (Degree or title) | | | 22b. ADDRESS <u>Troy Mo.</u> | | 22c. DATE SIGNED <u>9-30-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Oct 2-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Linn Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Weitzville 170</u> |
| 24. FUNERAL DIRECTOR <u>T.T. Pittman</u> ADDRESS <u>Weitzville</u> | | | 25. DATE RECD. BY LOCAL REG. <u>9-30-58</u> | | 26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u> |

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.

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 *Carlton J. Pitman*

Licensed Embalmer No. *4974*

P. O. Address *Wentzville*

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.