

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037644

STATE FILE NUMBER

FILED OCT 17 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9427

S. 300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>DI 1607-NO. 20TH ST</u>		d. STREET ADDRESS (If outside, give location) <u>1607-NO. 20TH ST.</u>	
Length of stay in 1b <u>65 YRS.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES-MARGARET-BUESCHER</u>			4. DATE OF DEATH Month Day Year <u>SEPT. 30TH 1958</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 12TH 1878</u>
9. AGE (In years last birthday) <u>79 YRS.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>O'FALLON - MO. C</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>ANDREW-BAIERLOTZER</u>	
13b. MOTHER'S MAIDEN NAME <u>HELEN-YAEGER</u>		14. NAME OF HUSBAND OR WIFE <u>JOSEPH-BUESCHER (DECD.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>LORETTA-KLOSTERMEYER = 1607-NO. 20TH ST.</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>HYPERTENSIVE HEART DISEASE</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>443x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized Arteriosclerosis & pulmonary emphysema</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART 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 WORK <input checked="" 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>Sept 24, 1958</u> to <u>Sept 30, 1958</u> and last saw her alive on <u>Sept. 29, 1958</u> Death occurred at <u>12:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Stephen A. Flatter M.D.</u>		22b. ADDRESS <u>8700 Riverview Blvd</u>	
22c. DATE SIGNED <u>10-1-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>OCT. 3RD 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>		(State) <u>MO.</u>	
24. FUNERAL DIRECTOR <u>Brockland Und. Co. 1827-HOGAN-ST.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 2 '58</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>mjb</u>			

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

Lawrence O. Gerber

Licensed Embalmer No. 4979

P. O. Address St. Louis, Mo.

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.