

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045482
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registration No. 12724

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>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>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>Faith Hospital</u>		Length of stay in 1b <u>6 weeks</u> <u>20790</u>	d. STREET ADDRESS (If outside, give location) <u>4967 Rosalie Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>G</u> Last <u>Buschorn</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1958</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1904</u>	9. AGE (In years last birthday) <u>54</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Payroll & Claim Clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Seidel Company</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER (Name) <u>Rudolph Buschorn</u>	13b. MOTHER'S MAIDEN NAME <u>Cecelia Golby</u>	14. NAME OF HUSBAND OR WIFE <u>Josephine Buschorn</u>
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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>416 X</u>	17. INFORMANT <u>Josephine Buschorn, 4967 Rosalie Avenue</u>	Address
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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>Rheumatic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
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 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.)
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from <u>Feb. 1954</u> to <u>Dec. 30, 1958</u> and last saw <u>him</u> alive on <u>Dec 29, 1958</u> Death occurred at <u>10:50 A M</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr. Charles M.D.</u> (Degree or title)	22b. ADDRESS <u>634 No Grand</u>	22c. DATE SIGNED <u>12/31/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>January 2, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>
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24. FUNERAL DIRECTOR <u>Math Hermann & Son, Inc., 2161 E. Fair</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 31 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
-57

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 *Clement McNeary*

Licensed Embalmer No. *3732*

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.