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All diseases in Part I must be causally related.

FILED MAR 10 1959  
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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006952  
STATE FILE NUMBER  
2 1782

S119061

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>6718 DELOR</b>	

3. NAME OF DECEASED (Type or print) <b>LEO H. BUSCHJOST</b>			4. DATE OF DEATH <b>FEBRUARY 18, 1959</b>		
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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>11/23/90</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.	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) <b>STOREKEEPER (RETIRED)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>CONFECTIONERY</b>	11. BIRTHPLACE (City and state or country) <b>ST. THOMAS, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>HERMAN BUSCHJOST</b>	13b. MOTHER'S MAIDEN NAME <b>CHRISTINE GERLING</b>	14. NAME OF HUSBAND OR WIFE <b>AGNES BUSCHJOST</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, state unknown) (If yes, give year or dates of service) <b>YES WW-I</b>	16. SOCIAL SECURITY NO. <b>488-30-6099A</b>	17. INFORMANT Address <b>VA HOSP RECORDS, 915 N GRAND, ST LOUIS, MO.</b>
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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) <b>TARULA MENINGITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	<b>134.1</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 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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. <input checked="" type="checkbox"/> VA attended the deceased from <b>2-9-59</b> to <b>2-18-59</b> and last saw him alive on <b>2-18-59</b> Death occurred at <b>10:05 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Robert E. Baker</b> (Type name or title) <b>Robert E. Baker M.D.</b>	22b. ADDRESS <b>VAH, 915 N GRAND, ST LOUIS, MO.</b>	22c. DATE SIGNED <b>2-18-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>FEB. 21, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MO.</b>
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24. FUNERAL DIRECTOR <b>KRIEGSHAUSER 4228 S. KINGS HIGHWAY</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 19 '59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

*me*

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 *E. A. Bennett* .....

Licensed Embalmer No. *3024* .....

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.