

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010761

STATE FILE NUMBER

FILED MAR 25 1959

Registration District No. _____

Primary Registration District No. _____

Registrar No. _____

2515

300
-57

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Ashland	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis, Mo. TOWN _____		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Perrysville Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Length of stay in 1b _____	d. STREET ADDRESS (If outside, give location) Rt. # 1 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Samuel Middle _____ Last Budd			4. DATE OF DEATH Month March Day 9 Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1875	9. AGE (In years last birthday) 83	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) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Ashland County, Ohio.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME W. Smith Budd	13b. MOTHER'S MAIDEN NAME Mary Hawks	14. NAME OF HUSBAND OR WIFE Anna
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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) No. Nil.	16. SOCIAL SECURITY NO. None	17. INFORMANT Anna Budd, Rt. # 1, Perrysville, Ohio. 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>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>331+</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>1 yr (?)</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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____
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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 2/25/1959 to 3/9/59 and last saw ^{her}him alive on 3/9/59
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Edward W. C. Ehrnschi, M.D.</u> (Degree or title)	22b. ADDRESS <u>3701 Grandel Sq</u>	22c. DATE SIGNED <u>3/10/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-22-59	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	23d. LOCATION (City, town, or county) Perrysville, Ohio. (State)
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24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. MAR 11 '59	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> 1190
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Stanley H. Dixon*
Licensed Embalmer No. *4193*
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.