

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014759
STATE FILE NUMBER
23484

FILED APR 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
-57
26
191
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 3729 So. Jefferson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Sophie S. Buchholz			4. DATE OF DEATH Month Day Year April 6, 1959		
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5. SEX Female	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 Feb. 27, 1897	9. AGE (In years last birthday) 62	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) housekeeping	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jacob Albrecht	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE William Buchholz, Sr.
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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	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address Mrs. O. Mittelstetter-3729 So. Jefferson
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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) Subdural Hemorrhage of the Brain. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) E 900.6 DUE TO (c) 45		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Do not include the terminal disease or condition of the patient.) Stopped in path of stairs to basement in apartment 1145 So. Jefferson Ave., April 6th 1959.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Do not include the terminal disease or condition of the patient.) Stopped in path of stairs to basement in apartment 1145 So. Jefferson Ave., April 6th 1959.
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20c. TIME OF INJURY Hour Month, Day, Year 1145 am 4 6 59	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 241 St. Louis Mo	20e. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo
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21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at 745 P. m on the date stated above; and to the best of my knowledge, from the causes stated.
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21a. SIGNATURE (Degree or title) Paul J. Simon	21b. ADDRESS 1300 Clark	21c. DATE SIGNED 4/8/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Apr. 9, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Lucas Cemetery	23d. LOCATION (City, town, or county) (State) Sappington, Missouri
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24. FUNERAL DIRECTOR ADDRESS Wacker-Helderle-3634 Gravois Ave.	25. DATE RECD. BY LOCAL REG. APR 8 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Delif J. Krupin*
Licensed Embalmer No. *3497*
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.