

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019002

STATE FILE NUMBER

2 5180

FILED JUN 11 1959

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 <u>MISSOURI</u> COUNTY <u>ST. LOUIS</u>	
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>ALEXIAN. BROS.</u>		d. STREET ADDRESS <u>3634 DUNNICA.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in <u>10 DAYS</u>			

3. NAME OF DECEASED (Type or print) First <u>JOSEPH.</u> Middle <u>N.</u> Last <u>BUDSICK</u>			4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1959</u>		
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>3-2-1882</u>	9. AGE (In years) Months <u>77</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EMERSON. ELEC.</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>MICHAEL BUDSICK.</u>			14. MOTHER'S MAIDEN NAME <u>NOT KNOWN.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If Yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>490-05-0276</u>		17. INFORMANT <u>Rosie BUDSICK, 3634 DUNNICA</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>Pneumonia hypostatica et lara</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Pneumonia ch. et malle loba</u> <u>7 months</u> DUE TO (c) <u>Arterio sclerotic heart disease</u> <u>7 months</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>		19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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.)				
20c. TIME OF INJURY Hour <u>        </u> Month, Day, Year a. m. <u>        </u> p. m. <u>        </u>					
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	

21. I attended the deceased from <u>4-13-59</u> to <u>5-28-59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>5/27/59</u> Death occurred at <u>6:15 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. Wachmeyer M.D.</u> (Degree or title)			22b. ADDRESS <u>4065 S. Grand</u>		22c. DATE SIGNED <u>MAY 29 '59</u>

23. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>6-1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PRK.</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS. MO</u>		
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FUNERAL DIRECTOR <u>Shing bormmelle, 3819 So Grand St.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAY 29 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300 1-56

693

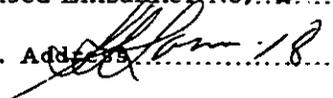
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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   
Licensed Embalmer No. 461  
P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.