URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1959

59-037463

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9807

ENDED

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 — Length of stay in 1b Years

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Anthony's Hospital — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 2608 Iowa Avenue — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Last BUSCHMANN

4. DATE OF DEATH Month October Day 24, Year 1959

5. SEX female

6. COLOR OR RACE white

7. Married ☐ Widowed ☐ Never Married ☒ Divorced ☐

8. DATE OF BIRTH 6/14/1872

9. AGE (last birthday) 87yrs.

IF UNDER 1 YEAR Months 4 Days 10 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress

10b. KIND OF BUSINESS OR INDUSTRY retired

11. BIRTHPLACE (City and state or country) Old Monroe, Mo.

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME Joseph Buschmann

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Marie Buschmann - Address 2608 Iowa Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia Lobar Hypostatic — INTERVAL BETWEEN ONSET AND DEATH 2 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cerebral hemorrhage — 12 days

DUE TO (c) Auricular fibrillation — 8 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arterio sclerosis - Senility 331x

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 October 12-59, to 10/24/59 and last saw her/him alive on Oct. 24-1959

Death occurred at 12:30 p.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] L. M.D.

22b. ADDRESS 2767 Gravois Ave.

22c. DATE SIGNED 10-24-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 10/27/59

23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery

23d. LOCATION (City, town, or county) St. Louis, (State) Missouri

24. FUNERAL DIRECTOR Gebken Sons - ADDRESS 2630 Gravois Ave.

25. DATE RECD. BY LOCAL REG. OCT 26 1959

26. REGISTRAR'S SIGNATURE Earl Smith. M.D. G.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

x

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Robert F. Gebke

Signature of Student Embalmer

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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