

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041637

FILED VS. NOV 16 1959

Primary Registration District No.

Registrar's No.

2 9234

STATE FILE NUMBER

MAILED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 10 Days		a. STATE Mo. b. COUNTY St. Louis		c. CITY OR TOWN Webster Groves Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 606 Sherwood Dr. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LULA Middle KATHRINE Last BUSSONG				4. DATE OF DEATH Month 10 Day 7 Year 1959				
5. SEX F		6. COLOR OR RACE W		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-26-1871		
9. AGE (last birthday) 88		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and state or country) Basel Switzerland		
12. CITIZEN OF WHAT COUNTRY USA								
13a. FATHER'S NAME John Leu			13b. MOTHER'S MAIDEN NAME Barbara Hansmann			14. NAME OF HUSBAND OR WIFE Thomas A Büssong		
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. None		17. INFORMANT Address Mrs. J.F. Allen 606 Sherwood Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon at recto-sigmoid junction							INTERVAL BETWEEN ONSET AND DEATH over 1 mo.	
DUE TO (b) _____ DUE TO (c) _____								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____								
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 8:30 Aug. 11 1959 to Oct. 7, 1959 and last saw her alive on Oct 7, 1959 Death occurred at 11:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) James B Jones M.D.				22b. ADDRESS 9313 Manchester Road Rock Hill 19, Mo.			22c. DATE SIGNED Oct 8, 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-9-1959		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS Parker-Aldrich Webster Groves Mo.				25. DATE RECD. BY LOCAL REG. OCT 8 '59		REGISTRAR'S SIGNATURE Earl Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

3. 12

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 Leslie Welch
Licensed Embalmer No. 4395

P. O. Address Palmer Grove

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.