

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004546

FILED FEB 1 1960 317

Registration District No. Primary Registration District No. 500 Registrar's No. 116

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Saint. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		Length of stay in 1b 61 days		c. CITY OR TOWN Saint Louis 15,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4124 Camelia		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Busking				4. DATE OF DEATH Month 1 Day 10 Year 60									
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 2-10-1884		9. AGE (last birthday) 75		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) Funeral driver				10b. KIND OF BUSINESS OR INDUSTRY Moydell		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME Fred Busking				13b. MOTHER'S MAIDEN NAME Elise Fischer				14. NAME OF HUSBAND OR WIFE Ruth Busking					
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. 497-10-5136		17. INFORMANT Address Mrs Ruth H Busking 4124 Camelia							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) Arterio-Sclerosis generalized Years			
DUE TO (c) Diabetes Mellitus Years													
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 type="checkbox"/> No <input type="checkbox"/> Unknown					
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.)									
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 Nov. 1, 1959 to Date of death and last saw her alive on Jan. 10, 1960 Death occurred at 3:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) W. F. Oberst M.D.						22b. ADDRESS 917 August Rd, Apt 35, Mo			22c. DATE SIGNED Jan 11, 1960				
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 1-13-60		23c. NAME OF CEMETERY OR CREMATORY BEAUFORTAINE CEMETERY			23d. LOCATION (City, town, or county) St. Louis		23e. STATE Mo.				
24. FUNERAL DIRECTOR MOYDELL FUNERAL HOME 1926 ALLEN AVE.				25. DATE RECD. BY LOCAL REG. 1-12-60		26. REGISTRAR'S SIGNATURE John B. Murphy M.D.							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wadley F. Kaelland

Licensed Embalmer No. 4950

P. O. Address St. Louis

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