

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008005

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2126** STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ALEXIAN BROS Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3654 - VIRGINIA		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First JOHN Middle BUCHMILLER Last				4. DATE OF DEATH FEB. 21 1960 Month Day Year											
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 MAR. 13 1882		9. AGE (last birthday) 77		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE WORKER				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13a. FATHER'S NAME AUGUST BUCHMILLER				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE LILLIAN BUCHMILLER							
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. 498-12-4791		17. INFORMANT LILLIAN BUCHMILLER				Address 3654 3 VIRGINIA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Cerebrum Hemorrhage										INTERVAL BETWEEN ONSET AND DEATH 2 day					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) Acute Congestive Heart Failure			2 2 1/2		
DUE TO (c) Chronic Respiratory Defection - Emphysema															
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 Month, Day, Year a.m. p.m.															
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 Feb 1 - 1960 to Feb. 21/60 and last saw her him alive on 2/20/60 Death occurred at 1-25 PM m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) C. L. Street M.D.						22b. ADDRESS 3606 Geavois				22c. DATE SIGNED 2/23/60 (State)					
23b. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23c. DATE FEB. 24 1960		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.				23d. LOCATION (City, town, or county) ST. LOUIS MO							
24. FUNERAL DIRECTOR Thomas Hutes 2906 Geavois				25. DATE RECD. BY LOCAL REG. FEB 23 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.									

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M.D.

1-4³⁰ 12m 6'ave

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 Eleanora Brown

Licensed Embalmer No. 340

P. O. Address 2906 gl

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.