

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017715

FILED VS APR 29 1960

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1262 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in 1b <u>2-wks.</u>	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>St. Mary's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>221 No. Grand Blvd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Reverend Francis</u> Middle <u>X.</u> Last <u>Busch S.J.</u>			4. DATE OF DEATH Month <u>April</u> Day <u>17th.</u> Year <u>1960</u>		
--	--	--	--	--	--

5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/1880</u>	9. AGE (last birthday) <u>80</u>	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) <u>Catholic Priest</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGION</u>	11. BIRTHPLACE (City and state or country) <u>Minn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
--	---	---	---

13a. FATHER'S NAME <u>Ferdinand Busch</u>	13b. MOTHER'S MAIDEN NAME <u>Anna M. Weimar</u>	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Rev. Thomas F. Thro, S.J., 221 N. Grand Blvd.</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>Branchogenic Ca. metastatic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>to adrenals, heart & brain.</u>	
	DUE TO (c) <u>Gen. arteriosclerosis</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>	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.) <u>none</u>
--	---	--

20c. TIME OF INJURY Hour <u>none</u> Month <u>none</u> Day <u>none</u> Year <u>none</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.) <u>none</u>	20f. CITY, TOWN, OR LOCATION <u>none</u> COUNTY STATE
--	--	---

20e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>none</u> COUNTY STATE
---	---

21. I attended the deceased from 2-26-52 to 4-17-60 and last saw him alive on 4-17-60
Death occurred at 7:26 PM. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Dee or title) <u>Robert E. Tao, M.D.</u>	22b. ADDRESS <u>4161 Lindell Blvd</u>	22c. DATE SIGNED <u>4-18-60</u>
--	---------------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/20/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Seminary</u>	23d. LOCATION (City, town, or county) <u>Florissant, Mo.</u> (State)
---	----------------------------	---	--

24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u> ADDRESS <u>3840 Lindell Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>4-18-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
--	---	--

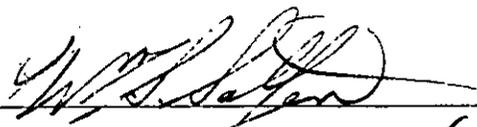
DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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



Licensed Embalmer No. 469

P. O. Address 3840

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.