

**FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-022293**  
STATE FILE NUMBER

INDEXED

Registration District No. 38 Primary Registration District No. 3096 Registrar's No. 346

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>5 days</u>	c. CITY OR TOWN <u>EMMA</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>P.O. Box 77</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>BUESING</u> Last <u>BUESING</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>1-4-97</u>	9. AGE (last birthday) <u>63</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>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Lafayette County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13a. FATHER'S NAME <u>LOUIS BUESING</u>		13b. MOTHER'S MAIDEN NAME <u>MINNIE ELLIS</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>_____</u>		16. SOCIAL SECURITY NO. <u>_____</u>	17. INFORMANT Address <u>University Medical Records</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>Cardiac failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old myocardial Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>May 1960</u> <u>to</u> <u>June 1960</u>	
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 <u>6-8-60</u> to <u>6-13-60</u> and last saw her alive on <u>6-13-60</u> Death occurred at <u>10:20/A</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Michael J. Anigian M.D.</u>			22b. ADDRESS <u>U. of Mo. Medical Center</u>		22c. DATE SIGNED <u>6/13/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/13/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Concordia, Missouri</u>		23d. LOCATION (City, town, or county) (State) <u>Concordia, Missouri</u>		
24. FUNERAL DIRECTOR <u>Lyman Sprinkle Columbia, Mo.</u>		ADDRESS <u>_____</u>	25. DATE RECD. BY LOCAL REG. <u>June 19, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Serial

Process

Form 1

Date

Place

11 Jun 1960

For use in connection with

Name of decedent

Walter

APAL

Co

1944

State

Illinois

Place of interment

JUN 21 1960

**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

*George J. Keenan*

Licensed Embalmer No. 4423

P. O. Address Columb

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.