

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047099

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3693

FILED JAN 9 1962

AMENDED

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|---|---|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sappington | | Length of stay in 1b YRS. | | c. CITY OR TOWN Sappington | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grandview Farm | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Grandview Farm | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First FLORENCE Middle PARKER Last BUSCH | | | | 4. DATE OF DEATH Month Dec Day 25 Year 1961 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 6/3/1881 | | 9. AGE (last birthday) 80 | | 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) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | | 11. BIRTHPLACE (City and state or country) Richmond Va. | | | 12. CITIZEN OF WHAT COUNTRY U. S. A | | | | |
| 13a. FATHER'S NAME Dr. W. W? Parker | | | 13b. MOTHER'S MAIDEN NAME Ellen Jordan | | | 14. NAME OF HUSBAND OR WIFE Adolphus Busch 3rd | | | | | | | |
| 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. No | | 17. INFORMANT Address #6 Colonial Hill Creve Couer Mrs. Herbert Condie | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | | | | | | |
| 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 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 Dec. 22 1961 to Dec 25 1961 and last saw her alive on Dec. 24, 1961 Death occurred at 345 A on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE George W. Stuee, M.D. | | | | | | 22b. ADDRESS 600 N. Union Blvd. | | | 22c. DATE SIGNED 12-26-61 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Dec 27 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem. | | | 23d. LOCATION (City, town, or county) St. Louis Mo | | | (State) | | | |
| 24. FUNERAL DIRECTOR C. R. Lupton and Sons 7233 Delmar | | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. 12-26-61 | | 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864
P. O. Address St. Louis, Mo.

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.