

# MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047100

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3724

STATE FILE NUMBER

AMENDED

FILED JAN 9 1962

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MEHLVILLE</u>		Length of stay in 1b <u>70 YRS</u>		c. CITY OR TOWN <u>MEHLVILLE</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>RT 9 - BOX 531 BECKER RD</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RT 9 - BOX 531</u>		
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>H.</u> Last <u>BUSCH</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>27</u> Year <u>1961</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-9-1879</u>		
				9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>HENRY BUSCH</u>			13b. MOTHER'S MAIDEN NAME <u>AUGUSTA SANDER</u>			14. NAME OF HUSBAND OR WIFE <u>IDA BUSCH</u>		
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>NIL</u>		17. INFORMANT <u>IDA BUSCH</u> Address <u>RT 9 - BOX 531 BECKER RD ST LOUIS 29 MO</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>Chronic Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Chronic</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>General Arteriosclerosis</u>							<u>Chronic</u>	
DUE TO (c) <u>Leishmaniasis</u>								
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 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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>						
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>Feb 23, 61</u> to <u>Dec 27, 61</u> and last saw him alive on <u>12/22/61</u> Death occurred at <u></u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Roy C. Driggers M.D.</u> (Degree or title)				22b. ADDRESS <u>7702 Irony Ave.</u>		22c. DATE SIGNED <u>12/27/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC-30-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE CEM.</u>		23d. LOCATION (City, town, or county) <u>LEMAV, MO</u>		
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME, MEHLVILLE MO.</u> ADDRESS <u></u>				25. DATE RECD. BY LOCAL REG. <u>12-28-61</u>		26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</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

*Gustav W. Dinter*

Licensed Embalmer No. 432

P. O. Address St. Louis

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.