

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017441

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4065** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED APR 17 1963**

1. PLACE OF DEATH  
a. COUNTY: **Missouri**  
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: **St. Louis** Length of stay in 1b: **5 weeks**  
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: **Missouri Baptist Hospital** Inside Limits: Yes  No   
d. STREET ADDRESS (If outside, give location): **5438 Shreve Ave.** Reside on Farm: Yes  No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE: **Missouri** b. COUNTY: **St. Louis**  
c. CITY OR TOWN: **St. Louis** Inside Limits: Yes  No   
d. STREET ADDRESS: **5438 Shreve Ave.** Reside on Farm: Yes  No

3. NAME OF DECEASED (Type or print) First: **Louis** Middle: **H.** Last: **Buchmiller** 4. DATE OF DEATH Month: **April** Day: **10** Year: **1963**

5. SEX: **male** 6. COLOR OR RACE: **white** 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH: **9-22-1886** 9. AGE (last birthday): **76** IF UNDER 1 YEAR: Months: **76** Days: **0** IF UNDER 24 HR: Hours: **0** Min: **0**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **Retired Gas Operator** 10b. KIND OF BUSINESS OR INDUSTRY: **Combustion Engineering** 11. BIRTHPLACE (City and state or country): **St. Jacob, Ill.** 12. CITIZEN OF WHAT COUNTRY: **U.S.A.**

13a. FATHER'S NAME: **August Buchmiller** 13b. MOTHER'S MAIDEN NAME: **Kathryn Hoel** 14. NAME OF HUSBAND OR WIFE: **Charlotte Buchmiller**

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates): **no** 16. TY NO.: **6** 17. INFORMANT: **Mrs. Charlotte Buchmiller, 5438 Shreve Ave.** Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Sepsis & Toxemia & Electrolyte Imbalance** INTERVAL BETWEEN ONSET AND DEATH: **6 days**  
DUE TO (b) **Small Intestine & Urinary Fistula** **10 days**  
DUE TO (c) **Surgery for carcinoma of Rectum with Bladder Involvement** **1 yr.**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) **Advanced age & Mild Arteriosclerosis**  
PART III. If deceased was female was there a pregnancy in last 90 days:  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.) **154x**

20c. TIME OF INJURY Hour: **2:30 am** Month, Day, Year: **April 10, 1963**

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): **via motor** 20f. CITY, TOWN, OR LOCATION: **St. Louis** COUNTY: **St. Louis** STATE: **Missouri**

21. I attended the deceased from **April 6, 1963** to **April 10, 1963** and last saw him alive on **April 9, 1963**  
Death occurred at **2:30 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: **Charles E. Green, M.D.** (Degree or title) 22b. ADDRESS: **6079 Grand Blvd.** 22c. DATE SIGNED: **April 10, 1963** (State)

23a. BURIAL, CREMATION, REMOVAL (Specify): **removal** 23b. DATE: **4-13-63** 23c. NAME OF CEMETERY OR CREMATORY: **Keystone Cemetery** 23d. LOCATION (City, town, or county) (State): **St. Jacob, Illinois.**

24. FUNERAL DIRECTOR: **Math Hermann and Son, Inc. 2161 E. Fair St. Louis 7, Missouri.** ADDRESS: **2161 E. Fair St. Louis 7, Missouri.** 25. DATE RECD. BY LOCAL REG.: **APR 11 1963** 26. REGISTRAR'S SIGNATURE: **Roan Smith, M.D.**

VS 300 Rev. 4/59

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DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

68

**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: Julius R Brown  
Licensed Embalmer No. 5145

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.