

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

14017

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **4003**
City **St. Louis** (No. **4337**) **De Soto Ave.**

File No.....
Registered No. **3331**
St..... Ward)

2. FULL NAME

(a) Residence. No. **4337 De Soto Ave.** St. **9** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Henry Bussick**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan. 16, 1870**
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
60 2 15

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **At Home**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Illinois**
(STATE OR COUNTRY)

10. NAME OF FATHER **Anton Schumacher**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER **Katharina Blatogis**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

14. INFORMANT **Henry Bussick**
(Address) **4337 De Soto Ave.**

15. FILED **Jan 19 1930** **Wm. C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 1 1930**
17. I HEREBY CERTIFY, That I attended deceased from **March 27 1930**, to **April 1 1930**, and that I last saw him **alive on April 1 1930**, and that death occurred, on the date stated above, at **7:15 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
apoplexy - cerebral hemorrhage
non Traumatic
(duration) yrs. mos. **4** ds.

CONTRIBUTORY (SECONDARY) **Hemiplegia previous attack**
apoplectic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Home**
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Paralysis**
(Signed) **Alfred Hoesly**, M. D.
4/2, 1930 (Address) **4244 W. Florissant**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Laurel Hill** DATE OF BURIAL **Apr. 4 1930**

20. UNDERTAKER **Math. Hermann** ADDRESS **2161 S. Fair Co.**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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