

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

Do not use this space.

37514

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... *Illmoir* (No. *3757 Olive St*)..... St. Ward)

File No.....
Registered No. **10590**
St. Ward)

2. FULL NAME

Johnson H Bucher
(a) Residence No. *3757 Olive St* St. *19* Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mary Bucher*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr 7 1861*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
69 8 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... *Painter*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Ohio*

10. NAME OF FATHER *Jacob Bucher*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Switzerland*

12. MAIDEN NAME OF MOTHER *Margaret Kleyer*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Switzerland*

14. INFORMANT *Elmer Bucher*
(Address) *3757 Olive St*

15. FILED *NOV - 8 1930* *May C. Starker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov. 6 1930*

17. HEREBY CERTIFY, That I attended deceased from *Oct 29*, 19*30*, to *Nov 6*, 19*30* that I last saw him alive on *Nov 5*, 19*30*, and that death occurred, on the date stated above, at *11:40 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mr. Myocarditis
9:30
8:15 A
(duration) yrs. mos. ds.
18. CONTRIBUTORY *Cerebral Hemorrhage (Primary)*
(SECONDARY) *Ch. Hypertension* (duration) *5* yrs. *6* mos. ds.
Alzheimer's - Hemiplegia

18. WHERE WAS DISEASE CONTRACTED.....
IF NOT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *H. Walter Egermann*, M. D.
. 19 (Address) *1225 W. D. Bldg.*

*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 DATE OF BURIAL
Stoto Mo *11/8 1930*

20. UNDERTAKER ADDRESS
A. Ellis 5240 Schmar St

