

No. 2
4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13129
State File No. 3559
Registrar's No.

MAY 13 1941

Registration District No. 791

Primary Registration District No. 1003

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17
9
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6915 Arthur Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Mo. (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
93
(d) Street No. 6915 Arthur Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Gertrude Buehner
3. (b) If veteran, name war None
3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 24th
year 1941 hour 1 minute P.M. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive 23rd years
7. Birth date of deceased. Oct. 1890
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-25-40
....., 19....., to 4-24-41, 19.....;
that I last saw her or alive on 4-24-41, 19.....;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
50 6 1 hr. min.

Immediate cause of death Carcinomatosis, generalized
Duration 1 plus year

9. Birthplace Cambridge Mass.
(City, town, or county) (State or foreign country)

Due to Primary Carcinoma of Ovaries
Due to.....

10. Usual occupation School Teacher

Other conditions (Include pregnancy within 3 months of death)
Major findings: Inoperable Carcinoma of ovaries, (7-12-40)

11. Industry or business.....

MOTHER FATHER { 12. Name Adam Buehner
13. Birthplace Germany
(City, town, or county) (State or foreign country) U
14. Maiden name Mina
15. Birthplace Germany
(City, town, or county) (State or foreign country) U

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Martha Buehner
(b) Address 6915 Arthur Ave.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....

17. (a) Burial (b) Date thereof 4-26-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus

(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director Kriegshauser Mortuar
(b) Address 4228 So. Kingshighway Blvd.

es While at work? (Specify type of place) (e) Means of injury 0

19. (a) APR 25 1941 (b) J. H. Brudick
(Approved local registrar) (Registrar's signature)

23. Signature B. O. A. Seib (M. D. or other) M.D.
Address 2323 Lafayette Ave. Date signed 4-25-41

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *Reinhold K. Lohman*

Licensed Embalmer No. *3395*

P.O. Address.....

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 this body is not embalmed, fact should be so stated above.