

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 194817

Primary Registration District No. 3063

Registrar's No. 833

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

96  
32

1. PLACE OF DEATH:

(a) County St. Louis Clayton

(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mon. 2 days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Gardenville  
(If outside city or town limits, write "RURAL.")

(d) Street No. 4663 Oldenberg Ave  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Samuel Buechlein

3. (b) If veteran, name war ?

3. (c) Social Security No. 499-03-2905

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4  
year 1943 hour 7 minute: 50 A.M.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ida Buechlein

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased: Apr. 1, 1873  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-2-43  
\_\_\_\_\_, 19\_\_\_\_, to 4-4-43, 19\_\_\_\_;  
that I last saw h. im. alive on 4-4-43, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>0</u>	<u>3</u>	_____ hr. _____ min.

Immediate cause of death respiratory failure Duration 5 MIN

Due to pulmonary edema + con 12 HRS  
gestion

Due to adenocarcinoma of 1 YR.  
rectum

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Adenocarcinoma of rectum

Of operations \_\_\_\_\_

Of autopsy Hemoperitoneum Hydrothorax

10. Usual occupation Iron worker

11. Industry or business unemployed

MOTHER FATHER {

12. Name Samuel Buechlein

13. Birthplace Unknown Switzerland  
(City, town, or county) (State or foreign country)

14. Maiden name Annie Martin

15. Birthplace Unknown Holland  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

16. (a) Informant Ida Buechlein

(b) Address 4663 Oldenberg

17. (a) Burial (b) Date thereof Apr 6, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director John S. Ziegler

(b) Address 7027 Gravois Ave.

19. APR 7 1943 (b) E. H. Mc  
(Date received local registrar) (Registrar's signature)

23. Signature Robert A. Hall (M. D. or other) M.D.

Address ST. LOUIS COUNTY HOSP Date signed 4-5-43

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**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..... *B. J. Kudwell* .....

Licensed Embalmer No. *3877* .....

P. O. Address..... *7027 Illinois* .....

**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.**