

No. 2  
5-43  
5-17-39  
X36671

Coroner.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 4 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 127  
Registrar's No. 842

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St Louis Mo  
(b) City or town St Louis Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution City Hospital  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution 1 Day  
(Specify whether  
In this community 2 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County 000  
(c) City or town St Louis Mo 17  
(If outside city or town limits, write "RURAL") 96  
(d) Street No. 4711 Ashland  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME William W Busch  
3. (b) If veteran, name war None  
3. (c) Social Security No. None  
4. Sex M 5. Color or Race W  
6. (a) Single, widowed, married, divorced 9  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 26  
year 1944 hour 6 minute 00 AM  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

7. Birth date of deceased Oct 2nd 1872  
(Month) (Day) (Year)  
8. AGE: Years 71 Months 3 Days 24  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Corchaer Hypertrophy, Pylonephritis  
Chronic - artifice sclerotic  
Due to non calcareous  
pyelonephritis  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 95

MOTHER FATHER  
12. Name Unknown  
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9  
16. (a) Informant Mrs. Hannah E. James  
(b) Address 6201 Page  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 1943  
(Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park  
18. (a) Signature of funeral director Hackmann  
(b) Address St. Clair Mo  
19. (a) JAN 27 1944 (b) J. F. Bredsch  
(Date received local registrar) (Registrar's signature)

Physician \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
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 3  
23. Signature Alfred J. Perry (M. D. or other) 3008  
Address Deputy Coroner Date signed 1-27-44

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

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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 *Howard A. Rowland*.....

Licensed Embalmer No. *3014*.....

P. O. Address *Othello, 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 this body is not embalmed, fact should be so stated above.**