S. No. 2
M—5-42
v. 5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 6 1945

Registration District No. 87

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9497

Primary Registration District No. 3017

Registrar's No. 38

1. PLACE OF DEATH:

(a) County: Cooper

(b) City or town: Boonville Mo.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution Jan. 11-45 (Specify whether
In this community Life.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Howard

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

(d) Street No.: 1 Mi. West U.S. Hy. 40 on 98 Hy.
(If rural, give location)

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

3. (a) PRINT FULL NAME: HERBERT HARRY BUSCHMEYER

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Male

5. Color or race: White

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

6. (b) Name of ~~husband~~ or wife: Isabell Goodman

6. (c) Age ~~of husband~~ or wife if alive: 46 years

7. Birth date of deceased: Oct. (Month) 21 (Day) 1901 (Year)

8. AGE: Years 43 Months 4 Days 17 If less than one day ____ hr. ____ min.

9. Birthplace: Howard Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER
12. Name: William H. Buschmeyer
13. Birthplace: Warren Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name: Clara A. Lindemeyer
15. Birthplace: Marion (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Fred Buschmeyer
(b) Address: Boonville Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/21/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Pleasant

18. (a) Signature of funeral director: C. S. Pleuneon
(b) Address: New Franklin Mo.

19. (a) Mar-21-45 (Date received local registrar) (b) Dr Chas Swap (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18 year 1945 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from August 5, 1944, to March 18, 1945; that I last saw him alive on March 17, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	24 hrs.
Due to: Coronary Sclerosis	2 yrs.
Due to:	
Other conditions: Chronic Myocarditis (Include pregnancy within 3 months of death)	2 yrs.

Major findings: Of operations: Colloid Goiter. Thyroidectomy at Mayo Clinic - 12/44

Of autopsy: Same as above

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: W. H. Zigler (M. D. or other) M.D.

Address: Boonville Mo. Date signed 3/22/45

1058

(Licensed Embalmer's Statement on Reverse Side)

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

7-2

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4/5/45

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 H. L. Hall

Licensed Embalmer No. 3515

P. O. Address New Franklin 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.