

No. 2  
5-43  
5-17-39  
X3657

State File No. \_\_\_\_\_  
Registrar's No. 7063

FILED AUG 31 1945  
Registration District No. 318

Primary Registration District No. 1003

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:  
Firman Desloge Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community About 18 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

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

(d) Street No. 3707 N 25 Street  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Buthe, Ethel

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F / 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 \_\_\_\_\_ years

7. Birth date of deceased 2 26 1926  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

19 5 12 hr. min.

9. Birthplace St. Libory ILL.  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Joseph Buthe

13. Birthplace St. Libory ILL.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Lammers

15. Birthplace Westphalon Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mary Buthe

(b) Address 3707 N 25 St

17. (a) Burial (b) Date thereof 8-13-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Boehner Boehner

(b) Address 2228 St Louis Ave

19. (a) AUG 11 1945 (b) J. F. Budeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8-8-45 day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 5:20 P.M.

21. I hereby certify that I attended the deceased from 8-4-45  
19 \_\_\_\_\_ to 8-8-45 19 \_\_\_\_\_  
that I last saw or alive on 8-8-45 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Infarction of myocardium due to embolism. *uncertain*

Due to detachment of mural thrombi. *uncertain*

Due to Recurrent aortic valve. *uncertain*

Other conditions Pericarditis with effusion of  
(Include pregnancy within 3 months of death) *uncertain*

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Confirmed diagnosis given above.

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 \_\_\_\_\_

23. Signature S. D. Brown (M. D. or other) MD  
Address 13255 Grand Date signed 8/9/45

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

**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: *John Agonoska*  
.....  
Licensed Embalmer No. *3398*  
.....  
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.