

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7300-2033**
Registrar's No. **2033**

Registration District No. **1003** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4715a Ashland 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)

3. (a) PRINT FULL NAME **Charles H. Buschen**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Theresa Buschen** 6. (c) Age of husband or wife if alive **?** years
7. Birth date of deceased **January 18, 1853.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
93 1 9 hr. min.

9. Birthplace **Germany** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business

MOTHER FATHER { 12. Name **Unknown** 13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown** 15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Miss Clara Buschen**
(b) Address **4715a Ashland Ave.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Mar. 2, 1946.** (Month) (Day) (Year)
(c) Place: burial or cremation **Bellefontaine Cemetery**

18. (a) Signature of funeral director **Calvin F. Feutz Funeral Home**
(b) Address **4828 Natural Bridge Blvd.**
19. (a) **MAR 1 1946** (Date received local registrar) (b) **J. F. Bredeest** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **4715a Ashland Ave.** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **27th** year **1946** hour **3:15** minute **P.** M.

21. I hereby certify that I attended the deceased from **2-1-** 19**46** to **2-27-** 19**46**
that I last saw him alive on **2-27-** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis (Acute)** 4 days
Nephritis (Chronic) 2 yrs
Due to **Age** 1/31

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) Home while at work? **No** (c) Means of injury **0**
23. Signature **E. W. Freeman** (M.D. or other)
Address **3532 Washington Ave.** Date signed **2/28/46**

(Licensed Embalmer's Statement on Reverse Side)

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.....

Ralph Linder

Licensed Embalmer No. *4275*

P. O. Address *St. Louis, 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.