

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24143

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6837

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: St. John's 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 _____
 years, months or days)

3. (a) PRINT FULL NAME WILLIAM J. BUOL

3. (b) If veteran, name war None
 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 Irene
 6. (c) Age of husband or wife if alive 52 years
 7. Birth date of deceased Oct. 12 1892
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 9 19 hr. min.

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

10. Usual occupation Custodian11. Industry or business Anheuser-Busch Inc.12. Name William A. Buol13. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)14. Maiden name Caroline Klugmann15. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)16. (a) Informant Irene Buol(b) Address 3139 Hampton Ave.17. (a) Burial (b) Date thereof 8-4-48
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Resurrection Cem.18. (a) Signature of funeral director Kriegshauser Und. Co.(b) Address 4228 So. Kingshighway Bl.19. (a) AUG 4 - 1948 (b) J. F. Dudeck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County oac
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3139 Hampton Ave.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1
 year 1948 hour 11:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from 25 July
1948 to 1 Aug 1948
 that I last saw him alive on 1 Aug 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Hypostatic pneumoniaDue to paralytic ileus

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 _____

23. Signature A. F. Catanzaro (M. D. or other) 6Address 2715 Clifton Date signed 3 Aug 48

(Licensed Embalmer's Statement on Reverse Side)

A. F. CATANZARO

WRITE PLAINLY—USE UNFADING BLACK INK—MAINTAIN A RECORD

6837

Mr. & Mrs. J. W. Stover
715 Clifton Ave. N. 4

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 Richard W. Stover

Licensed Embalmer No. 4007

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.