

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH27562
State File No. 7731
Registrar's No.FILED SEP 13 1948
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:
De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Two Hours
(Specify whether
In this community..... 30 years
years, months or days)

3. (a) PRINT
FULL NAMEEmanuel Buk

3. (b) If veteran,
name war.....

3. (c) Social Security No.
488-16-8677

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife..... Alma Poser Buk
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased June 28, 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 2 3 hr. min.

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

10. Usual occupation Cabinet Maker
General Steel Castings Corp.

11. Industry or business.....

12. Name Unknown
13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elvera Beckebrede
(b) Address 115 Waverly, Webster Groves, Mo
Burial Sept. 3, 1948

17. (a) (Burial, cremation, or removal) (b) Date thereof.....
(Month) (Day) (Year)
(c) Place: burial or cremation Immanuel Lutheran Cemetery
St. Charles Mo.

18. (a) Signature of funeral director BEIDERWIEDEN F. HOME INC.
(b) Address 1936 St. Louis Ave.

19. (a) SEP 2 1948
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4463 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 August day 31,
year 1948 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from
Sept 27 1948 to Aug 31 1948
that I last saw him alive on Aug 31 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 2 hrs

Due to Arterio-Sclerosis + Hypertension 1 yr

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 sta-
tistically.

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) (c) Means of injury

23. Signature C. F. Lindeman (M. D. or other) M.D.
Address 4412 E. Shenandoah Date signed 9/2/48

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Carl H. Lindeman
4126a Shreve Ave.

12-3:30

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 _____

Licensed Embalmer No. _____

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.