

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24653

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6422**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis University City</b>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <b>N.R. 7910 Gannon</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Baptist</b>			

3. NAME OF DECEASED (Type or Print) <b>Annie Buchmueller</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7-23-49</b>		
a. (First)		b. (Middle)		c. (Last)	

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 23rd 1860</b>	9. AGE (In years last birthday) <b>88</b>	IF UNDER 1 YEAR Months Days	IF UNDER 11 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At. Home</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Henry Wm. Kamp</b>	13b. MOTHER'S MAIDEN NAME <b>Henrietta Butt</b>	14. NAME OF HUSBAND OR WIFE <b>Samuel Buchmueller</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>Nil</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Benn Corawell</b>	ADDRESS <b>7910 Gannon St. Louis, Mo.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>fracture hip - fractured clavicle</b> DUE TO (c) <b>...</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Dr. R. M. Zuercher, Deputy Coroner 7/24/49</b>			

19a. DATE OF OPERATION <b>11-8-48</b>	19b. MAJOR FINDINGS OF OPERATION <b>Fr. Neck. R. Femur. Fr. R. Wrist</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SOURCE <b>HOMICIDE</b> (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <b>St. Louis / Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>11-5-48 6p.m.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fell</b>
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22. I hereby certify that I attended the deceased from **11/6, 1948**, to **7/23, 1949**, that I last saw the deceased alive on **7/23, 1949**, and that death occurred at **2 a.m.**, from the causes and on the dates stated above.

23a. SIGNATURE <b>Dr. R. M. Zuercher</b> (Degree or title)	23b. ADDRESS <b>845 Northrup Bldg</b>	23c. DATE SIGNED <b>7/24/49</b>
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24a. REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-23-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Washington, Missouri</b>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>JUL 24 1949</b> <b>F. B. Jasater</b>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Av. H. Hoppe Inc. 4700 Washington</b>
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WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Albert G. Stapp*

Licensed Embalmer No. *297M*

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.