

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25755**
 BIRTH NO. _____ REG. DIST. NO. **319** PRIMARY REG. DIST. NO. **4469** Registrar's No. **40**

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
a. COUNTY STE. GENEVIEVE	b. CITY (If outside corporate limits, write RURAL and give township) STE. GENEVIEVE		c. LENGTH OF STAY (In this place) 2 1/2 yrs	a. STATE MISSOURI	b. COUNTY STE. GENEVIEVE MO
d. FULL NAME OF HOSPITAL OR INSTITUTION COUNTY HOME 5			d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED (Type or Print) LAWRENCE			a. (First)	b. (Middle)	c. (Last) BUCHHOLTZ	4. DATE OF DEATH (Month) (Day) (Year) July 8 - 1949		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE (1)	8. DATE OF BIRTH MAR. 15 1872		9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LAWRENCETON MO		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME MORRIS BUCHHOLTZ	13b. MOTHER'S MAIDEN NAME ELIZABETH SELINGER	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME William Buchholtz French Village Mo	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1943
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		45 MO
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Apoplexy			1945
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept. 2, 1943**, to **July 8, 1949**, that I last saw the deceased alive on **July 5, 1949**, and that death occurred at **5:17** m., from the causes and on the date stated above.

23a. SIGNATURE Arthur E. [Signature]	(Degree or title) (M.D.)	23b. ADDRESS St. Genevieve Mo	23c. DATE SIGNED 7-8-1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE July 10 1949	24c. NAME OF CEMETERY OR CREMATORY ST. LAWRENCE	24d. LOCATION (City, town, or county) (State) LAWRENCETON MO
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DATE REC'D BY LOCAL REG. July 11 - 49	REGISTRAR'S SIGNATURE L. Karl [Signature]	FUNERAL DIRECTOR'S SIGNATURE M. Karl [Signature]	ADDRESS Osceola C. Baskin & Co. Geneseo Mo
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RECEIVED 7-16-49
District Health Officer No. 4
District File Number 749-932
Date Filed _____

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. 311

working under my personal supervision.

Student Adrian F. Ehler
Student Embalmer

Signed Geo. C. Basler

Licensed Embalmer No. 1985

P. O. Address 180 Stevenson Dr

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.