

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 569

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Remay</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Remay</u> 4860	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>214 Adelia</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>214 Adelia</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Jerry</u> b. (Middle) <u>DON</u> c. (Last) <u>Buxrow</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3 2 1951</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>me</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		8. DATE OF BIRTH <u>Feb 20 1949</u>	
				9. AGE (In years last birthday) <u>2</u>	
				11. BIRTHPLACE (State or foreign country) <u>0</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>Us</u>	

13a. FATHER'S NAME <u>Orville Don Buxrow</u>		13b. MOTHER'S MAIDEN NAME <u>Arlene Duffel</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Orville Don Remay Mo</u>	

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, asthma, 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) <u>myocardial infarction</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Strangulation</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Heavy chest congestion</u>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>474</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 Feb 27, 1951, to Mar 2, 1951, that I last saw the deceased alive on Feb 27, 1951, and that death occurred at 11:30 A. M., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. Joseph S. Fisher</u>		23b. ADDRESS <u>7110 Michigan Ave</u>		23c. DATE SIGNED <u>3-2-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-2-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Jamesboro</u>	
		24d. LOCATION (City, town, or county) (State) <u>Ark</u>			

DATE REC'D BY LOCAL REG. <u>3-2-51</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donke MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Rowland Mortuary Service Inc.</u> 4104 Manchester Ave. St. Louis 10, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

WORYNE - WOE

WORYNE

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Howard P. Rawland

Signed
Student Embalmer [Signature]

Licensed Embalmer No. 3114

P. O. Address [Signature]

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.

2