

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6284

State File No.

FILED MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1468**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis 2179	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4151 Cleveland			d. STREET ADDRESS (If rural, give location) 17 4151 Cleveland		
3. NAME OF DECEASED a. (First) Augustus b. (Middle) Henry c. (Last) Buscher			4. DATE OF DEATH (Month) (Day) (Year) February 14, 1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 16, 1873	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 8 Days 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Nil		11. BIRTHPLACE (State or foreign country) St. Francis County, Missouri	
13a. FATHER'S NAME Jake Buscher		13b. MOTHER'S MAIDEN NAME Emilie Pernod		14. NAME OF HUSBAND OR WIFE Gora Ellen Buscher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Earl Buscher 3909a Gravois City	

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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of Prostate ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis Heart Emphysema, Pericard		INTERVAL BETWEEN ONSET AND DEATH	
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) 7:15 a.m. 2/14/52		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 177K	

22. I hereby certify that I attended the deceased from **July, 1951, to Dec, 1951**, that I last saw the deceased alive on **Dec 26, 1951**, and that death occurred at **6:45 a.m. 2/14/52** from the causes and on the date stated above.

23a. SIGNATURE Manner Perceon M D Barnes Hospital (Degree or title)		23b. ADDRESS Bonne Terre, Mo.		23c. DATE SIGNED 2/14/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb. 18, 1952		24c. NAME OF CEMETERY OR CREMATORY St. Francis Memorial Pk.	
24d. LOCATION (City, town, or county) (State) Bonne Terre, Mo.					

DATE REC'D BY LOCAL REG. FEB 15 1952		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U&L Co. 7814 S. Bdwy City II	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Kosocan
Directors Office
Barnes Hospital
1st Floor

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.....
Student Embalmer

Signed *Harry J. Schenck*

Licensed Embalmer No. *2679*

P. O. Address *7874 S. Broadway*

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.