

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **9753**

FILED MAR 29 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2381**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		2189
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>			d. STREET ADDRESS (If rural, give location) <b>3211 Caroline</b>		
3. NAME OF DECEASED (Type or Print), a. (First) <b>MARY</b>		b. (Middle) <b>FRANCES</b>	c. (Last) <b>BUCK</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MARCH 12, 1952</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Feb 23 1877</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nil</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Anthony Braun</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Jacob</b>	14. NAME OF <del>MARRIED</del> WIFE <b>Charles Buck</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Alma Deelo 3211 Caroline</b>		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Hypertensive Cardiovascular disease</b>				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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>334X</b>			
22. I hereby certify that I attended the deceased from <b>2-15-52</b> , 19___, to <b>3-12-52</b> , 19___, that I last saw the deceased alive on <b>3-12-52</b> , 19___, and that death occurred at <b>8:20A m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>F. J. O'Leary M.D.</b>		(Degree or title)	23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>3-12-52</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>March 15 52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>MAR 13 1952</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>E. Schuer</b>	ADDRESS <b>3125 Lafayette</b>	

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

2483 (Licensed Embalmer's Statement on Reverse Side)

**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

*John B. Hollmer*

Licensed Embalmer No. *21014*

P. O. Address *3125 Lafayette*

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.