

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23585**

FILED JUN 19 1953

BIRTH NO. _____ REG. DIST. NO. **328** PRIMARY REG. DIST. NO. **6112** Registrar's No. **14**

1. PLACE OF DEATH a. COUNTY SCOTT			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY SCOTT		
b. CITY (If outside corporate limits, write RURAL and give township) CHAFFEE		c. LENGTH OF STAY (In this place) 72	c. CITY (If outside corporate limits, write RURAL and give township) CHAFFEE		d. STREET ADDRESS (If rural, give location) RED #1 1000
d. FULL NAME OF HOSPITAL OR INSTITUTION RED #1					
3. NAME OF DECEASED (Type or Print) a. (First) MATIE		b. (Middle)	c. (Last) BUCHER		4. DATE OF DEATH (Month) (Day) (Year) 5-30-53
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 7-2-1880		9. AGE (In years last birthday) Months Days 72 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) NEW HAMBURG MO		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME JOE SCHERER		13b. MOTHER'S MAIDEN NAME MATIE WESTRICH LAWRENCE		14. NAME OF HUSBAND OR WIFE EDWARD D. BUCHER	
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 ADDRESS Mr. Ralph Vetter Chaffee		

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) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH.
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension			
		DUE TO (c) Arteriosclerosis			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

18a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X		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 **April 9, 1953**, to **May 30, 1953**, that I last saw the deceased alive on **May 29, 1953**, and that death occurred at **10:30 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. P. Brogan D.O.		23b. ADDRESS Benton Mo.	23c. DATE SIGNED June 5, 1953
24a. BURIAL, CREMATION, REMOVAL (Specify) B	24b. DATE 6-2-53	24c. NAME OF CEMETERY OR CREMATORY ST. LAWRENCE	24d. LOCATION (City, town, or county) (State) NEW HAMBURG MO
DATE REC'D BY LOCAL REG. 6-15-53	REGISTRAR'S SIGNATURE Mrs. F. Bradley	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STUBBS FUNERAL HOME CHAFFEE MO	

(Licensed Embalmers' Statement on Reverse Side) **cm-stubbs MO**

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

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RECEIVED 6-17-53
SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 653-136

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

C. A. Lorberg

Licensed Embalmer No. 3812

P. O. Address Cape Girardeau

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.