

STANDARD CERTIFICATE OF DEATH

FILED SEP 24 1953

State File No. **32972**
Registrar's No. **8099**

BIRTH NO. **54949** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony's Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jefferson c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Festus d. STREET ADDRESS (If rural, give location) 29 Main Street	
3. NAME OF DECEASED (Type or Print) a. (First) Barbara b. (Middle) Ann c. (Last) Buff		4. DATE OF DEATH (Month) (Day) (Year) Aug. 18, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug. 15, 1953
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) St Louis, Mo.
13a. FATHER'S NAME Clyde Buff		13b. MOTHER'S MAIDEN NAME Maggie Becker	14. NAME OF HUSBAND OR WIFE -----

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 Clyde Buff, Festus, Missouri
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Atelectasis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature Birth (Gestation 26 wks.) DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	INTERVAL BETWEEN ONSET AND DEATH 3 day
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 762.5
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 Aug 15, 1953 to Aug 18, 1953, that I last saw the deceased alive on Aug 18, 1953, and that death occurred at 7⁰⁰ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) George A. O'Sullivan, M.D.	23b. ADDRESS 421 W. Schurmer	23c. DATE SIGNED 8-20-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 20, 53	24c. NAME OF CEMETERY OR CREMATORY Catholic	24d. LOCATION (City, town, or county) (State) Crystal City, Mo.
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DATE REC'D BY LOCAL REG. AUG 20 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Georgette Politta Crystal City
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9.0 (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

Not embalmed

Signed *Gentry B. Plutte*

Licensed Embalmer No. *3481*

P. O. Address *Crystal City*

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.