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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 14 1956

State File No. 19085

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 1333

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gasconade</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Richmond Heights</b>		c. CITY OR TOWN <b>Owensville</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>84 days</b>		e. STREET ADDRESS (If rural, give location) <b>Local</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Walter</b> b. (Middle) _____ c. (Last) <b>Buchholz</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 30, 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 31, 1899</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Owensville, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Frank Buchholz</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Poppenhouse</b>	14. NAME OF HUSBAND OR WIFE <b>Ruby Buchholz</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>Nil.</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Ruby Buchholz, Owensville, Mo.</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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Intra cerebral Hemorrhage - left</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3/6/56</b> <b>3/6/56</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Intra cerebral Hemorrhage - left middle cerebral.</b>		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>330x</b>			

19a. DATE OF OPERATION <b>May 9, 1956</b>	19b. MAJOR FINDINGS OF OPERATION <b>Subdural &amp; sub arachnoid hemorrhage - 330x</b>		20. AUTOPSY? YES <input checked="" 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) (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 **March 6, 1956**, to **May 31, 1956**, that I last saw the deceased alive on **5/30, 1956**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Walter Moore</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>6376 Clayton Rd</b>	23c. DATE SIGNED <b>6/31/56</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>5-30-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City</b>	24d. LOCATION (City, town, or county) (State) <b>Owensville, Mo.</b>

DATE REC'D BY LOCAL REG. <b>6-31-56</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Blomberg</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>
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(Licensed Embalmers' Statement on Reverse Side)

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

MAY 17 1944

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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. ....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.