

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 18 1956

State File No. **42801**
Registrar's No. **10852**

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| BIRTH MO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 10852 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY CHRISTIAN | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS | | c. LENGTH OF STAY (In this place) 4 da. | | c. CITY OR TOWN TAYLORVILLE | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S HOSPITAL | | | | e. STREET ADDRESS (If rural, give location) 602 S. WYANDOTTE | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) PAUL c. (Last) BUZZINGHAM | | | 4. DATE OF DEATH (Month) (Day) (Year) Nov. 26 - 1956 | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH SEPT. 20 - 1956 | | 9. AGE (In years last birthday) 2 | 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) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (City and State or Foreign Country) TAYLORVILLE, ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13a. FATHER'S NAME UNKNOWN | | 13b. MOTHER'S MAIDEN NAME LINDA BUZZINGHAM | | 14. NAME OF HUSBAND OR WIFE _____ | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME Jane Henrichsen ADDRESS 500 S Kingshughway | | | |
| 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* TRANSPOSITION OF GREAT VESSELS INTERVAL BETWEEN ONSET AND DEATH 2 mos ANTECEDENT CAUSES DUE TO (a) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 754.6 | | | | | | |
| 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 checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from 11-22-1956 , to 11-26-1956 , that I last saw the deceased alive on 11-26-1956 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Barbara Jones, M.D. | | | | 23b. ADDRESS 500 S Kingshughway, St Louis | | 23c. DATE SIGNED 11-27-56 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 11-27-56 | 24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | | 24d. LOCATION (City, town, or county) (State) Taylorville, Illinois | | |
| DATE REC'D BY LOCAL REG. NOV 27 1956 | | REGISTRAR'S SIGNATURE Paul Smith MD | | 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe | | ADDRESS 4700 Washington | |

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

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 *John J. Haines*
Licensed Embalmer No. *4108*
P. O. Address *St. Louis*

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.