

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14520

STATE FILE NUMBER

FILED MAY - 8 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's **3908**

Health,
Welfare
Public,
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Length of stay in lb 88 yrs. 10 5/8	d. STREET ADDRESS (If outside, give location) 5883 Enright Ave.
3. NAME OF DECEASED (Type or print) First HENRY Middle WILLIAM Last BUECKER		4. DATE OF DEATH Month April Day 22 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Electrical Supplies	9. AGE (In years last birthday) 88 yrs.
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Buecker		14. MOTHER'S MAIDEN NAME Charlotte Hunning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 491-16-9172	
17. INFORMANT Mrs. Willetta B. Lane, 5883 Enright Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Generalized			INTERVAL BETWEEN ONSET AND DEATH Years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUPLICATE TO (b) Parkinsonian Syndrome			5 yrs.
DUPLICATE TO (c) Hypertensive cardiovascular 350X			14 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral prostatic hypertrophy, prostatic obstruction, Prostatitis, decubitus-terminal pneumonia.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 1943 to 4-22-57 and last saw ^{him} alive on 4-21-57 Death occurred at 2345 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. Fred W. Clark</i> (Degree or title) MD		22b. ADDRESS 864 Hamilton Blvd St. Louis 12 Mo	22c. DATE SIGNED 4-22-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-24-57	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. APR 24 '57	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>

PA. 1-2354
Hours 1-4 PM
Call at 4:30 Monday

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 Delis J. Krissin

Licensed Embalmer No. 349

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.