

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

57 022398
State File No.

FILED JUN 20 1957

318

1003

5503
Registrar's No.

BIRTH NO. 42206-57 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St Louis		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 30 Saint Louis Maternity		e. STREET ADDRESS (If rural, give location) 3452 Osage Street	
3. NAME OF DECEASED (Type or Print) a. (First) Buscher b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) June 3 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH June 3 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Month Days IF UNDER 12 HRS. Hours Min. 55
11a. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Roy Jack Buscher		13b. MOTHER'S MAIDEN NAME Mary Loraine Schmidt	
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 Mary Loraine Buscher ADDRESS Above	
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.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MEDICAL CERTIFICATION Multiple Congenital Anomalies Atelectasis at the Newborn</u> b. ANTECEDENT CAUSES DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>Achondroplasia</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7593	
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 type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 3, 1957, to June 3, 1957, that I last saw the deceased alive on June 3, 1957, and that death occurred at 11:50 P.M., from the causes and on the date stated above.			
23a. SIGNATURE <u>Thomas W. Ross</u> (Degree or title) M.D.		23b. ADDRESS St. Louis Maternity Hosp.	
23c. DATE SIGNED 6-7-57		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 6-29-57		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) St. Louis, Mo.		(State)	
DATE REC'D BY LOCAL REG. JUN 13 57		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howland Akers</u> ADDRESS 404 Main Street	

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.....

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.