

FILED NOV 8 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **10313**

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 causally 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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Saint Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>4643 Lee Avenue, 15</b>
3. NAME OF DECEASED (Type or print) First <b>AUGUST</b> Middle <b>ADAM</b> Last <b>BUSS</b>		4. DATE OF DEATH <b>October 30th, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18th, 1877</b>
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheetmetal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet Metal</b>	11. BIRTHPLACE (City and state or country) <b>New York, N. Y.</b>
13. FATHER'S NAME <b>Albert Buss</b>		14. MOTHER'S MAIDEN NAME <b>Francisca Kaeser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-09-8846A</b>	17. INFORMANT Address <b>Mrs. Minnie Buss, 4643 Lee Avenue, 15</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Prostate Hypertrophy</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>610x</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sept 28 57</b> <b>7</b>
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 _____ a. m. _____ p. m. Month _____ Day _____ Year _____			
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 <b>Aug 7 1957</b> to <b>Oct 30 57</b> and last saw her <b>1:30 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated. Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>W. W. Mamedorosky M.D.</b>		22b. ADDRESS <b>986 Acadia Bldg</b>	22c. DATE SIGNED <b>11/1/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11/2/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethany Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., St. Louis, 15, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 1 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith mo</b> <b>m.j.s</b>

FEI-1-530 P.M.

**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 A. Mlsna* .....  
Licensed Embalmer No. *410*

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.