

pt. Health,  
, & Welfare  
S. Public  
alth Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41809

STATE FILE NUMBER

FILED DEC 13 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11743**

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ev. 1-57

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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) <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Park Lane Hospital</b>		Length of stay in lb <b>6 Weeks</b>	d. STREET ADDRESS (If outside, give location) <b>5034 Alcott Avenue</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ERNST</b> Middle <b>A.</b> Last <b>BUSCHELBERG</b>			4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>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>February 28, 1870</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Cigar Store Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Ernst A. Buschelberg</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Wink</b>		14. NAME OF HUSBAND OR WIFE <b>Julia Buschelberg</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>Unknown</b>	17. INFORMANT Address <b>Mrs. Julia Buschelberg 5034 Alcott Avenue</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>Acute ventricular failure</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Subtle</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic myocarditis</b>					<b>1 year</b>
DUE TO (c) <b>Chronic hepatitis</b>					<b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Rheumatoid arthritis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT - SUICIDE - HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>592x</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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>10-23-57</b> to <b>12-6-57</b> and last saw him alive on <b>12-6-57</b> Death occurred at <b>5:50 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>E. N. Snyder M.D.</b> (Degree or title)			22b. ADDRESS <b>705 Oliv St</b>		22c. DATE SIGNED <b>12-6-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 9, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old St. Marcus Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc. 2161 E. Fair</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>DEC 6 57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> <i>ms</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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 *Walter B. Burnley* .....  
Licensed Embalmer No. *42020* .....  
P. O. Address *Albany, N.Y.* .....

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.