

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2711

STATE FILE NUMBER

FILED FEB 14 1958

318

1003

1237

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5622 Delor St.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5622 Delor St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last EDNA BUCKEL			4. DATE OF DEATH Month Day Year Jan. 31 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1888		9. AGE (In years last birthday) 69 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) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Martin Maenner		13b. MOTHER'S MAIDEN NAME Mary Mohrman		14. NAME OF HUSBAND OR WIFE Philip Buckel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Philip Buckel 5622 Delor St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension DUE TO (c) 332x			INTERVAL BETWEEN ONSET AND DEATH 30 min 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 <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 Nov. 26, 56 to JAN. 31, 58 and last saw her alive on JAN. 31, 1958 Death occurred at 7:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Barbara Johnson M.D.			22b. ADDRESS 6400 Morganford		22c. DATE SIGNED 2-1-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 4, 1958	23c. NAME OF CEMETERY OR CREMATORY S/S Peter & Paul Cem.		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway			25. DATE RECD. BY LOCAL REG. FEB 3 '58		26. REGISTRAR'S SIGNATURE Carl Smith

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms which be traced. All diseases in Part I must be causally related.

300
1-57

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 *William White*

Licensed Embalmer No. *7291*
P. O. Address *4228 Lakewood Highway*

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.