

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027656

FILED VS AUG 10 1959

Registration District No. 517

Primary Registration District No. 590

Registrar's No. 2111

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. JOHN</u> Length of stay in 1b <u>MONS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RUGH MANOR REST HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>UNIVERSITY CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>7219 DORSETT</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>LOUIS</u> Last <u>BUHRMAN</u>	4. DATE OF DEATH Month <u>AUGUST</u> Day <u>4</u> Year <u>1959</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-9-1896</u>	9. AGE (last birthday) <u>63 YRS</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHARMACIST</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>KNIGHT DRUG CO</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>LOUIS BUHRMAN</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZABETH BETZ</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW I</u>	16. SOCIAL SECURITY NO. <u>444-03-8892</u>	17. INFORMANT <u>OLIVER E BUHRMAN</u> Address <u>8628 92nd Ave RD</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial</u> DUE TO (b) <u>hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>1 year</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____
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21. I attended the deceased from July 1958 Aug 1959 and last saw ^{her}him alive on Aug 3 - 59
 Death occurred at 601 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>W A Schumacher M.D.</u>	22b. ADDRESS <u>8863 Fredoyan</u>	22c. DATE SIGNED <u>8-5-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-59 LAKE CHARLES</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO MISSOURI</u>
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24. FUNERAL DIRECTOR <u>EARL Willemson</u> ADDRESS <u>9709 BACKLAND RD</u>	25. DATE RECD. BY LOCAL REG. <u>8-5-59</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Earl D. Miller

Licensed Embalmer No. 3501
P. O. Address Greenville 14

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.. (Failure to conform 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.