

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035503

FILED VS OCT 28 1959 - 70

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 54

ENDED

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| 1. PLACE OF DEATH a. COUNTY <u>Clark</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Clark</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP or TOWN) <u>Clayton</u> Length of stay in 1b <u>years</u> | | c. CITY OR TOWN <u>Clayton</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (if outside, give location) _____ Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|--------|--|---|-------|-----|--|--|------|
| 3. NAME OF DECEASED (Type or print) <u>Anna Francis Buschling</u> | | | 4. DATE OF DEATH <u>10-18-1959</u> | | | | | |
| First | Middle | | Last | Month | Day | | | Year |

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|--------------------------------|---|---|---|--------------------------------------|---|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-23-81</u> | AGE (last birthday) <u>78</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>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTH PLACE (City and state or country) <u>Clark Co. Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Charles W. Baker</u> | 13b. MOTHER'S MAIDEN NAME <u>Polly Ann Banks</u> | 14. NAME OF HUSBAND OR WIFE <u>Harold H. Buschling</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, OR COAST GUARD? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | 16. SOCIAL SECURITY NO. <u>_____</u> | 17. INFORMANT <u>Harold H. Buschling</u> Address <u>Boston Mo</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>Coronary occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | |
| DUE TO (b) _____ | | |
| DUE TO (c) _____ | | |

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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 checked="" 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 _____ | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |
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|---|-------------------------------------|---------------|--------------|
| 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 7-27-59 to 10-18-59 and last saw her alive on 10-18-59
 Death occurred at 2:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Harold H. Buschling</u> | 22b. ADDRESS <u>Clinton Mo</u> | 22c. DATE SIGNED <u>Oct 19 59</u> |
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| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | 23b. DATE <u>10-20-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fragel Crematory</u> | 23d. LOCATION (City, town, or county) (State) <u>Clark Co Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Fred J. Karle</u> | ADDRESS <u>Kahoka Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>10/22-59</u> | 26. REGISTRAR'S SIGNATURE <u>J. H. Reid</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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Fred J Karle

Licensed Embalmer No. 1023

P. O. Address Kahoka Mo

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.