

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-010340

STATE FILE NUMBER

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY <b>COLE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>COLE</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON CITY, MO.</b>		Length of stay in 1b		c. CITY OR TOWN <b>JEFFERSON CITY, MO.</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>ST MARYS HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>303 Montana Str.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RITA ROSE BUECHTER</b>				4. DATE OF DEATH Month Day Year <b>MARCH 25, 1960</b>				
5. SEX <b>Female</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>7/6/22</b>	9. AGE (last birthday) <b>37</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b>	IF UNDER 24 HR Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST LOUIS, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>JOSEPH BUSHMAN SR.</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOW.</b>			14. NAME OF HUSBAND OR WIFE <b>OTTO BUECHTER</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>486-30-7909</b>		17. INFORMANT Address <b>Otto Buechter J C Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Shock due to cerebral shut down of Electrolyte imbalance</b>							<b>3 d</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Peritonitis</b>							<b>10 d</b>	
DUE TO (c) <b>Respiratory failure (secondary) plus</b>							<b>70 d</b>	
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		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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>June 1951</b> to <b>3-25-60</b> and last saw her alive on <b>March 25 - 1960</b> Death occurred at <b>3:40 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>William A Cox MD</b>				22b. ADDRESS <b>Jefferson City Mo.</b>			22c. DATE SIGNED <b>3-28-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/28/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony</b>		23d. LOCATION (City, town, or county) <b>St. Anthony, Mo.</b>		STATE	
24. FUNERAL DIRECTOR <b>Lyphaster Gull</b> ADDRESS <b>J C MO.</b>			25. DATE RECD. BY LOCAL REG. <b>25 March 1960</b>		26. REGISTRAR'S SIGNATURE <b>R.P. Harris MD J. Richter</b>			

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 Sylvester Fuller

Licensed Embalmer No. 432

P. O. Address Jefferson Co

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