

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042556

FILED VS NOV 28 1960

Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 125

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>RURAL-MERAMEC</u>		Length of stay in 1b <u>1 YR 4 MO 1 DAY</u>		c. CITY OR TOWN <u>LEMAY</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>ST. JOSEPH'S HILL INFIRMARY</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>340 TACOMA DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>BUCHHOLZ SR.</u> Last				4. DATE OF DEATH Month <u>NOV</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>MALE</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>MAY 30 1884</u>	
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (City and state or country) <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED BAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>UNKNOWN BUCHHOLZ</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>BARBARA BUCHHOLZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>493-03-4406</u>		17. INFORMANT Address <u>BARBARA BUCHHOLZ 340 TACOMA DR</u>			
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>Pneumonia</u> DUE TO (b) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome - Gen. arteriosclerosis</u>						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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 <u>Sept 1959</u> to <u>Nov 5 1960</u> and last saw her/him alive on <u>11/3/60</u> Death occurred at <u>9:45 a.m. 11/5/60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Patrick C. Hogan MD</u>				22b. ADDRESS <u>2623 Telegraph Rd Lemay</u>		22c. DATE SIGNED <u>11/7/60</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>NOV 8. 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PARK</u>		23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO.</u>	
24. GENERAL DIRECTOR <u>Thomas Hestia</u>		ADDRESS <u>2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>11-8-60</u>		26. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 62 AGR ST

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

James C. Will

Licensed Embalmer No. 4347

P. O. Address 2906

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.