

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318 1003 9588 -61-038360
 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9588
 FILED OCT 26 1961

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

1. PLACE OF DEATH a. COUNTY				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) OR TOWN <u>ST. LOUIS</u>			Length of stay in 1b		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3136 IOWA AVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ALINDA</u> Middle <u>BUEL</u> Last				4. DATE OF DEATH Month <u>OCT</u> Day <u>14</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 8, 1889</u>	9. AGE (last birthday) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>COLLINSVILLE ILL</u>		12. CITIZEN OF WHAT COUNTRY <u>U-S-A</u>
13a. FATHER'S NAME <u>ANDREW SUTTER</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>ANDREW H. BUEL SR.</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>NONE</u>		17. INFORMANT Address <u>ANDREW BUEL JR 9954 DUKE DRIVE</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>Myocardial Infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary artery sclerosis</u>							<u>4 yrs</u>
DUE TO (c) <u>4201</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>					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 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 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>4/8/58</u> to <u>10/14/61</u> and last saw her alive on <u>10/14/61</u> Death occurred at <u>4/P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Edward W. Czerninski M.D.</u>			22b. ADDRESS <u>3701 Emerald Sq</u>		22c. DATE SIGNED <u>10/16/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 18 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER + PAUL CEM</u>		23d. LOCATION (City, town, or county) <u>ST. LOUIS</u>		STATE <u>MO.</u>	
24. FUNERAL DIRECTOR <u>Thomas Kates 2906 Gravois</u>			25. DATE RECD. BY LOCAL REG. <u>OCT 17 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith. M.D.</u>		

1-3 2/21/48

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 grove

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.