

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003270

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 43

AMENDED

FILED FEB 14 1962

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. COUNTY St Charles			a. STATE Mo		b. COUNTY St Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Charles		Length of stay in 1b 1 da		c. CITY OR TOWN St Ann		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Josephs Hosp			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 10713 Forview			
3. NAME OF DECEASED (Type or print) Deborah Buessink			4. DATE OF DEATH Feb 5 1962					
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Apr 1 1961		
9. AGE (last birthday) 0		IF UNDER 1 YEAR Months 10 Days 4		IF UNDER 24 HR Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St Charles Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Frank Buessink			13b. MOTHER'S MAIDEN NAME Helen James			14. NAME OF HUSBAND OR WIFE -----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Frank Buessink Address St Ann Mo			
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) Acute Bilateral Lobar Pneumonia						1 hour		
DUE TO (b) Acute Confluent Pneumonia						1 hour		
DUE TO (c)								
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		
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 April 1961 to Feb 5 1962 and last saw her alive on Feb 5 1962 Death occurred at 7:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Clare B. Vatterott M.D. (Degree or title)				22b. ADDRESS St Louis County Mo		22c. DATE SIGNED Feb 6 1962		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2/7/62		23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) (State) St Louis Mo		
24. FUNERAL DIRECTOR ADDRESS Ortmann F Home 9222 Lackland Overland Mo				25. DATE RECD. BY LOCAL REG. FEB 6-62		26. REGISTRAR'S SIGNATURE Marcella Wilson		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 15 1962

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 Al C. Ostmann

Licensed Embalmer No. 3475

P. O. Address _____

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.