

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-003563

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 479

STATE FILE NUMBER

FILED JAN 19 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Length of stay in 1b <u>6 days</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>		c. CITY OR TOWN <u>Springfield</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>St. Louis Children's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>1220 E. Meadowmere</u>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle Last <u>Busiek</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>8,</u> Year <u>1962</u>			5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-61</u>		9. AGE (last birthday) IF UNDER 1 YEAR Months <u>7</u> Days <u>days</u> Hours <u>hours</u> Min. <u>min.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Springfield Ill</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Erwin F. Busiek</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy Garrison</u>		14. NAME OF HUSBAND OR WIFE <u>never married</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Jane Henriksen</u>		500 s. Kingshighway St. Louis, Mo			
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>Cardiac arrest</u> DUE TO (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>754.5</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Post op Cleft lip</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								INTERVAL BETWEEN ONSET AND DEATH	
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 <u>3:37pm</u> Month, Day, Year <u>1-3-62</u>		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 <u>Springfield, Missouri</u>		STATE <u>Missouri</u>	
21. I attended the deceased from <u>1-3-62</u> , to <u>1-8-62</u> and last saw her/him alive on <u>1-8-62</u> Death occurred at <u>3:37pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Albert H. Schwann M.D.</u> (Degree or title)				22b. ADDRESS <u>500 S. Kingshighway St. Louis, Missouri</u>		22c. DATE SIGNED <u>1-8-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 10, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Gorman-Scharpf Funeral Home Springfield, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>JAN 11 1962</u>		26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

031 P. 241 03. 1977

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 *Rob Embalmed*
Lawrence
Licensed Embalmer No. _____
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.