

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019340  
STATE FILE NUMBER

MAY 27 1958 Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <b>Ray</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond TWP</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Norborne, 6170</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ray Co. Hospital</b>		Length of stay in 1b <b>1 Day</b>	d. STREET ADDRESS (If outside, give location) <b>N Duncan</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>Lee</b> Last <b>Buckner</b>			4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1958</b>		
--------------------------------------------------------------------------------------------------	--	--	---------------------------------------------------------------------	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-1902</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
-------------------------	---------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------	----------------------------------------------	---------------------------------------------------	------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home,</b>	11. BIRTHPLACE (City and state or country) <b>Norborne, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--------------------------------------------------------------------------------------------------------------------	------------------------------------------------------	--------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME <b>Phillip Buckner</b>	13b. MOTHER'S MAIDEN NAME <b>Fannie Jiles</b>	14. NAME OF HUSBAND OR WIFE <b>None</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>None</b>	17. INFORMANT <b>Ruth Ellen Holly Norborne, Mo.</b>	Address
------------------------------------------------------------------------------------------------------------------------	----------------------------------------	--------------------------------------------------------	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	4341
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Death occurred at **5:45 PM - 5-18-58** and last saw her alive on **5-18-58** at **6:00 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>B. E. Ray M.D.</b>	22b. ADDRESS <b>Richmond, Mo.</b>	22c. DATE SIGNED <b>5-19-58</b>
-----------------------------------------------------------	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>May 18 '58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Stemple Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Norborne Mo.</b>
-------------------------------------------------------------	--------------------------------	----------------------------------------------------------	----------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>Deitch Funeral Home Norborne, Mo.</b>	ADDRESS <b>5-24-1958</b>	25. DATE RECD. BY LOCAL REG. <b>5-24-1958</b>	26. REGISTRAR'S SIGNATURE <b>Mabel Jackson</b>
------------------------------------------------------------------	-----------------------------	--------------------------------------------------	---------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Ben W. Gibson* .....

Licensed Embalmer No. *2961* .....

P. O. Address *Carrollton* .....

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.