N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Carter

Township Johnson or Village

or City (NO. St.; Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 40267 B

Registration District No. 145 File No. 7

Primary Registration District No. 5208 Registered No. 23

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Theophelus Corbin Buckley

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	married

DATE OF BIRTH Oct (Month) 16 (Day), 1848 (Year)

AGE 68 yrs. 2 mos. 13 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Ky.

PARENTS

NAME OF FATHER Chad Buckley

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky.

MAIDEN NAME OF MOTHER Matilda Myers

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C C Buckley

(ADDRESS) Grandin Mo

Filed Jany 8th, 1917. Alva L Johnston REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec (Month) 29 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1916, to Dec 29, 1916, that I last saw h in alive on Dec 29, 1916, and that death occurred, on the date stated above, at 9:20 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

131

120

(Duration) 15 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) R R Watson M. D.

Dec 30, 1916 (Address) Grandin, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Grandin Cemetery

DATE OF BURIAL 12-31, 1916

UNDERTAKER W E McKinney

ADDRESS Grandin Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day) , 1_____ (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day) , 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____; that I last saw h_____ alive on _____, 191____; and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

1 _____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	**ADDRESS**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.