WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (NO. 1424 Singleton St.; 7 Ward)

Registration District No. 791 File No. 35794

Primary Registration District No. 1003 Registered No. 9093

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

2 FULL NAME Leonard Buckner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Cold

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Jan. (Month) 25 (Day) 1883 (Year)

7 AGE: 35 yrs. 8 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): Common

9 BIRTHPLACE (City or town, State or foreign country): Miss

PARENTS

10 NAME OF FATHER: James Buckner

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

12 MAIDEN NAME OF MOTHER: Not Ascertainable

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): not Ascertainable

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theresa Lee Buckner
(Address) 1424 Singleton St

15 Filed OCT 2 1918 Max C. Starkloff Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct 1st (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 26, 1918, to Oct 1, 1918 that I last saw her alive on Sept 31, 1918, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

1 A
108 Lobar Pneumonia
10 (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) La Grip
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Oct 1, 1918 (Address) 3500 Olive

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL: Greenwood
DATE OF BURIAL: Oct 5, 1918

20 UNDERTAKER: Harrison & McKoin
ADDRESS: 2906 Lawton av.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be filled in.

MISSOURI STATE BOARD OF HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... ; ..... St.; ..... Ward)

[If death occur hospital or insi give its NAME of street and nu

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

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

8 OCCUPATION

(a) Trade, profession, or particular kind of work .....

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., to ....., 191

that I last saw h..... alive on ....., 191

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. .....

(Signed) ..... M

....., 191..... (Address) .....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transie or Recent Residents)

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

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191
20 UNDERTAKER	ADDRESS