

C 27 1898

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

Do not use this space.

37305

1. PLACE OF DEATH

County Joplin
Township Joplin
City Joplin Mo (No. _____)

Registration District No. 411
Primary Registration District No. 2002

File No. _____
Registered No. 513
St. _____ Ward _____

2. FULL NAME

Oliver W. Buck

(a) Residence No. 1718 Kentucky St. Ward _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

mar.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Mrs. Ella V. Buck

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 16-1851

7. AGE

YEARS MONTHS DAY If LESS than 1 day, hrs. or min.
77 4 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Insurance
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Retired

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Wisconsin

10. NAME OF FATHER

No Record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

No Record

12. MAIDEN NAME OF MOTHER

No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

No Record

14.

INFORMANT Mrs. Ella V. Buck
(Address) 1718 Ky. Ave

15.

FILED 11-28-18 Dr. A. S. Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 27 1918

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1917, to Nov. 27, 1918 that I last saw him alive on Oct. 10, 1917, and that death occurred, on the date stated above, at 8:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis

CONTRIBUTORY (SECONDARY) Paralysis (duration) 1 yrs. 6 mos.

(duration) 5 mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY: _____

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) J. Albert G. Bennett M. D.
11/28, 1918 (Address) Joplin Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mount Hope Nov. 28 1918

20. UNDERTAKER ADDRESS

Frank - Stevens Joplin Mo

Every item of information should be carefully supplied. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

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statement

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jasper
Township Joplin
City Joplin (No.) St. Ward

Registration District No. 411
Primary Registration District No. 2002

File No.
Registered No. 513
St. Ward

2. FULL NAME

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 1-14-19-29 Dr. A. B. Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 27 1928

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Nephritis
Paralysis (Progressive of spinal cord)
(duration) yrs. mos. da. (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) 1750A, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

N. B. ... should be careful to supply ... item of information in plain terms, so that it may be properly understood.
 EXACTLY. PHYSICIANS should state OCCUPATION is very important.
 STRAHS SHALL NOT RECEIVE A FEE FOR CERTIFICATION COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-37365