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.

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

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

Do not use this space. 1893

1. PLACE OF DEATH
County Jackson Registration District No. 399 File No.
Township Kaw Primary Registration District No. 1002 Registered No. 486
City Kansas City (No. 3408 Central Ave St. Ward)

2. FULL NAME Charles H. Bucher
(a) Residence. No. 3408 Central Ave St. 5 Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 12, 1856
7. AGE 73 Years 10 Months 17 Days. If LESS than 1 day, ...hrs. or ...min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Traveling
(b) General nature of industry, business, or establishment in which employed (or employer) Salesman
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

PARENTS
10. NAME OF FATHER Andrew Bucher
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Mary E. Younkers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ? (STATE OR COUNTRY)
14. INFORMANT Chester S. Bucher
(Address) Scarsdale, N.Y.
15. FILED 1-31-1929 M M Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 29 1929
17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to Jan 29, 1929 that I last saw h... alive on Jan 26, 1929, and that death occurred, on the date stated above, at 5:22 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremic Poisoning
(duration) ... yrs. ... mos. 3 ds.
CONTRIBUTORY (SECONDARY) Inflamation of Prostate gland
(duration) 2 yrs. ... mos. 29 ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) B Frank Watson, M.D.
1/30, 1929 (Address) 2401 Prospect

*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 Memorial Park. DATE OF BURIAL 2/1 1929
20. UNDERTAKER Freeman Mortuary ADDRESS 19 W. 42nd St.

2 2 135 135

1:30 to 3
2401 Prospect

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..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1002 Registered No. 486

City K. City (No....., ... St. ..... Ward)

2. FULL NAME Charles H. Bucher

(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. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	Wid

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.

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)

PARENTS

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) Unknown

14. INFORMANT .....
(Address)

15. FILED 1/31, 1929 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 29 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

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).....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

SUPPLEMENTARY

...PHYSICIANS should state ...atement of OCCUPATION is very important.
...ain terms, so that it ...
CAUSE OF De...
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S - 1893