

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

Do not use this space.

10352

1. PLACE OF DEATH

County Greene
Township Walnut Grove

Registration District No. 375
Primary Registration District No. 5450

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

2. FULL NAME

Abner Buster

(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. da.

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) Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 9 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
67 4 3

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Randolph County, Ark
(STATE OR COUNTRY)

10. NAME OF FATHER William Buster

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

12. MAIDEN NAME OF MOTHER Matilda Lucien

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

14. INFORMANT Bettie Hurst
(Address) Walnut Grove, Mo.

15. FILED 5/11/1929 L. M. Colure REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar - 12th 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar - 12, 1929, to Mar - 12, 1929 that I last saw him alive on Mar - 12, 1929 and that death occurred, on the date stated above, at 5 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy
820 1/2
97 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Arterio sclerosis
(duration) 5 yrs. mos. da.

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 physical
(Signed) L. D. MaBless, M. D.

3-14, 1929 (Address) Walnut Grove, Mo.

*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 Sumner County, Lebanon, Mo. DATE OF BURIAL 3/15 1929

20. UNDERTAKER J. A. Baird & Sons ADDRESS Walnut Grove, Mo.

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.

39
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1929
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2

**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 Greene Registration District No. 225 File No. 10352
 Township Walnut Grove Primary Registration District No. 2430 Registered No. _____
 City _____ (No. _____, St. _____ Ward)

2. FULL NAME

Abner Buster
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 9 - 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 4 3

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 3/14, 1929 L. McClure REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 12 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 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:

_____ (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 _____

20. UNDERTAKER _____ ADDRESS _____

N. B.—Every item of information should be carefully supplied. ACE 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. FEE: FARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-10352