

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

Do not use this space.

18358  
2403

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City K.C. MO (No. Gen. Hospital #2)

Registration District No. \_\_\_\_\_  
City Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Buckner, Frank

(a) Residence, No. 1113 E 17<sup>th</sup> St., 4 Ward.

(Usual place of abode) 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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 188

7. AGE YEARS 48 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Lee'sburgh (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Buckner Ben

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) no

12. MAIDEN NAME OF MOTHER Harriet M.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) no

14. INFORMANT Record Clerk (Address) Old City Hosp.

15. FILED 5/25 1929 M. M. Crowe REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5.24. 1929

17. I HEREBY CERTIFY, That I attended deceased from 5.21 - 5.24, 1929 that I last saw him alive on 5.23, 1929 and that death occurred, on the date stated above, at 1:30 A. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute Myocarditis  
Chr. Diffused Nephritis  
131  
93H (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 1290 (duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH Home  
9 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS Clinical & Laboratory  
(Signed) H. M. Smith, M. D.

5/25 .1929 (Address) Old City Hospital

\*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 Blue Ridge Lawn Cem. DATE OF BURIAL 5/25 1929

20. UNDERTAKER West, Gopfstein & Jones ADDRESS 1600 E 19<sup>th</sup>

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.

RECORDING UNIT THIS IS A PERMANENT RECORD

