

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

Do not use this space.

24148

PLACE OF DEATH

County Bole

Registration District No. 213

Township Jefferson

Primary Registration District No. 314

City Jefferson (No. 167)

File No. _____

Registered No. 167

St. _____ Ward _____

2. FULL NAME

Evelyn Josephine Buecker

(a) Residence. No. 1216 St. Marys 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 19-1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	1	3	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Jefferson City Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Geo. B. Buecker

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

12. MAIDEN NAME OF MOTHER Anna Strattman

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

14. INFORMANT G. B. Buecker
(Address) J. O. Mo.

15. FILED 7/19 1929 G. B. Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18-1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1928, to March 4 1929, that I last saw her alive on March 4 1929, and that death occurred, on the date stated above, at July 18 1929 Am.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Not listed (probably inherited)

CONTRIBUTORY (SECONDARY) 3 1/2 hrs (duration) 1 yrs. 3 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 General symptoms

(Signed) J. S. Summers M. D.

19 (Address) Jefferson City 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 St. Peters Cem. DATE OF BURIAL 7-19-1929

20. UNDERTAKER G. B. Neuvich ADDRESS J. O. Mo.

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.

AUG 22 1929

