

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

Do not use this space.

38299

1. PLACE OF DEATH

County St. Louis Registration District No. 1123
 Township Grandall Primary Registration District No. 6248 G
 City Jefferson (No. _____) St. _____ (Ward _____)

File No. _____
 Registered No. 428

2. FULL NAME Nancy Jane Buchanan

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 26 1829

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>100</u>	<u>3</u>	<u>3</u>	<u>3</u>	

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Ben May Sr

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Sam Gayhart
 (Address) Jefferson Mo

15. FILED Dec 3 1919 L. C. Brock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 28 1949

17. I HEREBY CERTIFY That I attended deceased from Nov 20 1949, to Nov 29 1949
 that I last saw h. _____ alive on Nov 26 1949, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Double fatal pneumonia

102/101/0 (duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? physical
 (Signed) Walter Kelly, M. D.
 _____, 19 _____ (Address) Jefferson

*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 Park Hill Cemetery DATE OF BURIAL DEC 19 1949

20. UNDERTAKER John Koch ADDRESS Jefferson 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.

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