

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

Do not use this space.

4142

1. PLACE OF DEATH
 County Duchesne Registration District No. 85
 Township St. Joseph - No. 140 Primary Registration District No. 1001
 City State Hospital No. 2 (No. State Hospital #2) St. _____ Ward _____

2. FULL NAME Alfred J. Buckner
 (a) Residence. No. State Hospital No. 2 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 Cal 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Married
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 2 - 18 58
 7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min.
71 11 13
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Labourer
 (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) unknown
 10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown
 12. MAIDEN NAME OF MOTHER unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown

14. INFORMANT State Hospital Records
 (Address) Dr. Joseph M. ...
 15. FILED FEB 17 1934 19 _____
John G. ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1934
 17. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1934, to Feb 15, 1934, that I last saw him alive on Feb 15, 1934, and that death occurred, on the date stated above, at 4 o'clock P. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
82A
 CONTRIBUTORY (SECONDARY) 74al
 (duration) yrs. mos. ds. _____
 18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DEATH? _____
 (Signed) J. S. Mills, M. D.
Feb 15 1934 (Address) State Hospital No. 2
 *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 City Cem DATE OF BURIAL Feb. 18 1934
 20. UNDERTAKER B. F. Graves ADDRESS 804 S-17th

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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