MAR 28 1930

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

Do not use this space.

6022

1. PLACE OF DEATH
County: Polk
Township: Benton
City: ..... (No. ..... St. ..... Ward)
Registration District No. 705
Primary Registration District No. 5934
File No. .....
Registered No. 2

2. FULL NAME: Alonzo Van Buskirk

(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR ~~DIVORCED (write~~ the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF
Not Known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1861

7. AGE: Years 69 | Months unknown | Days | If LESS than 1 day, ... hrs. or ..... min.

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) ..... (STATE OR COUNTRY) Iowa

PARENTS
10. NAME OF FATHER: William VanBuskirk
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: Lee Morris
(Address) Buffalo Mo

15. FILED Feb 8 1930 C W Glover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 7 19

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 7, 1930, that I last saw him alive on Feb 5, 1930, and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Lobar Pneumonia
108
(duration) ..... yrs. ..... mos. 3 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) T D Winkle, M. D.
Feb 8, 1930 (Address) Halfway 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: Reed Cemetery
DATE OF BURIAL: Feb 8 1930

20. UNDERTAKER: None
ADDRESS: XX

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.