

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

Do not use this space.
6996

1. PLACE OF DEATH

County Registration District No. **7911**
Township **1003**
City **St. Louis** (No. **3810**, **Finney**)
Primary Registration District No.

File No.
Registered No. **1861**
St. Ward

2. FULL NAME

Emma Buckner

(a) Residence. No. **3810 Finney** St., **11** Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **15** 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 **Colored** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 73 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **House - work**
(b) General nature of industry, business, or establishment in which employed (or employer) **laundry cleaning at home**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Lexington**
(STATE OR COUNTRY) **Kentucky**

10. NAME OF FATHER **unknown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **unknown**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Martha Sanders**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Kentucky**
(STATE OR COUNTRY)

14. INFORMANT **Marie McClarine**
(Address) **3810 Finney Ave**

15. FILED **May 21 1930** **May C. H. ...**
19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 20 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 10 - 1929** to **Feb 20 1930** that I last saw him **alive on Oct 15 1929** and that death occurred, on the date stated above, at **2:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio-Sclerosis
97
97B

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **Arterio Sclerosis**

(duration) yrs. mos. 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?

(Signed) **J. H. ...** M. D.
21 1930 (Address) **Franklin St. Bldg.**

*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 **Washington Park** DATE OF BURIAL **2/22 1930**

20. UNDERTAKER **Peoples Und. Co.** ADDRESS **3100 Franklin**

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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