

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

Do not use this space.

33125

1. PLACE OF DEATH

County Jackson
Township Ham
City Rock (No. 614 Charlotte St.)

Registration District No. 399
Primary Registration District No. 1003

File No. 33125
Registered No. 4559
St. _____ Ward _____

2. FULL NAME

Willie Buchanan
(a) Residence. No. 614 Charlotte St., _____ Ward. _____

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 22

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Janitor (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) Mo

10. NAME OF FATHER Henry Buchanan

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

12. MAIDEN NAME OF MOTHER Gertrude Buchanan

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

14. INFORMANT Henry Buchanan (Address) 614 Charlotte St

15. FILED 10/28 1930 M.M. Lewis REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-23 1930

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Oct. 23rd 1930 that I last saw him alive on Oct. 23, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23 Hr (duration) _____ yrs. 3 mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED From history at mo. IF NOT AT PLACE OF DEATH Penitentiary

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) Chas. E. Jones, M. D.

10/24 1930 (Address) 811 Independence Ave. N.E. 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 Blue Ridge Lave DATE OF BURIAL 10-29 1930

20. UNDERTAKER A. K. Moore ADDRESS 1820 E 18

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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Sta 2521