

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

Do not use this space.

7310

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St Louis MO.** (No. **2814 Franklin Ave.**)
Emma Lorain Buchanan

File No.
Registered No. **1621**
St. Ward)

2. FULL NAME

(a) Residence. No. **2814 Franklin Ave** St. **21** Ward.
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female		4. COLOR OR RACE Colored		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/10/30					
7. AGE YEARS		MONTHS		DAYS	
9		29		If LESS than 1 day, hrs. or min	
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work None					
(b) General nature of industry, business, or establishment in which employed (or employer) None					
(c) Name of employer					

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY) **St Louis Mo.**

10. NAME OF FATHER **Archie Buchanan**

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) **St Louis MO.**

12. MAIDEN NAME OF MOTHER **Iva Herendun**

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

14. INFORMANT **Archie Buchanan**
(Address) **2814 Franklin Ave**

15. FILED **FF2 - 4 10 30**
W. C. Starker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2/7/31** 19

17. I HEREBY CERTIFY, That I attended deceased from **2-9-31** to **2-7-31**, 19**31**, that I last saw him alive on **2-4/55**, 19**31**, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
108
(duration) yrs. mos. **5** ds.

CONTRIBUTORY (SECONDARY) **108**
(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 **Physical Exam.**
(Signed) **G. A. Cairns** M. D.
. 19 (Address) **3200 Lucas Ave.**

*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 **Greenwood Cem.** DATE OF BURIAL **Feb 9, 1931**

20. UNDERTAKER **Ellis Funeral Home** ADDRESS **2828 Stoddard St.**

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

