

MAR 5 - 1937

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis St. Ann's Hospital File No. 4375
 Registered No. 2194
 St. _____ Ward _____

2. FULL NAME

Stillbirth BUCKMANN
 (a) Residence, No. _____ St. nr Ward. Uniontown, Ky
 (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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEB 22 1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) ST LOUIS MO (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME ELLEN BUCKMANN

16. BIRTHPLACE (CITY OR TOWN) UNIONTOWN NY (STATE OR COUNTRY)

17. INFORMANT SISTER ZOE (ADDRESS) 5301 PAGE

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE Feb 28 1937

19. UNDERTAKER Charles Hatcher (ADDRESS) 5301 PAGE BLVD

20. FILED FEB 23 1937 J. T. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) FEB 22 1937

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him Still Born alive on _____, 19____

to have occurred on the date stated above, at 12.25 Am.

The principal cause of death and related causes of importance were as follows:

Infantile tetanus Date of onset

Other contributory causes of importance:

Bowel Rive Contracture of sternum

Name of operation none Date of _____

What test confirmed diagnosis? Routine Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no Date of injury _____, 19____

Where did injury occur? no (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) John B. O'Neill, M.P.

(Address) 3192 View Club Bldg

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.

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