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.

REC'D MAY 6, 1938

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

15790
Do not use this space.

1. PLACE OF DEATH
(a) County ST LOUIS Registration District No. 784
(b) Township ~~Clayton~~ Primary Registration District No. 107 Registered No. 719
(c) City Clayton (d) Street No. COUNTY HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ELEANOR MAURINE BUCHANAN 255
(a) Residence, No. 2829 EDGAR AVE St. [ ]
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
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
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 12 1938
7. AGE YEARS MONTHS DAYS 5 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. —
9. Industry or business in which work was done, as 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) (STATE OR COUNTRY) ST. LOUIS COUNTY MISSOURI

FATHER
13. NAME WILLIAM BUCHANAN
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) WEST. DES. MOINES IOWA

MOTHER
15. MAIDEN NAME MARGARET KEHOE
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) WEST. DES MOINES IOWA

17. INFORMANT (ADDRESS) Wm Buchanan 2829 Edgar Ave.
18. BURIAL, CREMATION, OR REMOVAL PLACE W. Des Moines DATE 4/23 1938
19. FUNERAL DIRECTOR (ADDRESS) Thomas J. Finan 8900 Bristol Ave.
20. FILED 4-21 1938 T. R. Meyer M. D. Dep. P. H. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 18 38
22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
I last saw h..... alive on ....., 19.... Death is said to have occurred on the date stated above, at 1:45 AM m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Icterus neonatorum	5 days

161 P.

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Physical signs Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? ..... (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 O'Connell M. D.
Coroner of St. Louis County, Mo.
707

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, John Ketter, Licensed Embalmer No. 3880

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed John Ketter

Licensed Embalmer No. 3880

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)