

REC'D AUG 19 1939

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

26585
Do not use this space.

1. PLACE OF DEATH

(a) County Polk Registration District No. 708
(b) Township Mc Kenley Primary Registration District No. 5937a Registered No. 2
(c) City _____ (d) Street No. _____ 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

Maudie Celine Buckner
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 22 - 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 5 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
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) Polk County, Mo.

FATHER 13. NAME William Manes

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

MOTHER 15. MAIDEN NAME Amanda Jenkins

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT (ADDRESS) Jim Buckner

18. BURIAL, CREMATION, OR REMOVAL PLACE Payne DATE June 13

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hatchison-Blue
Bolivar, Mo.

20. FILED July 28 1939 Mal Zumwalt
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 24 1939

22. I HEREBY CERTIFY That I attended deceased from June 24 1939 to June 24 1939
I first saw him alive on June 24 1939 Death is said to have occurred on the date stated above, at 4 P.M.
The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy Date of onset 6-24-39

Other contributory causes of importance: 87 W

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Doyle McKeown, M. D.

(Address) Bolivar, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

RECEIVED

District Health Officer No. 7,
District File Number 7-39-1232
Date Filed 8-12-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.