

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

SEP 15 1939

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

30365

Do not use this space.

1. PLACE OF DEATH

(a) County Shannon Registration District No. F23
(b) Township Anna Primary Registration District No. 1074 Registered No. _____
(c) City _____ (d) Street No. _____
(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

256 Ina May Buckner
(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE Y 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) May - 9 - 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
3 24

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) Mo

FATHER 13. NAME Jack Buckner

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

MOTHER 15. MAIDEN NAME Veils

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

17. INFORMANT (ADDRESS) Jack Buckner
Shannon, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Anna DATE 9-4- 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) none

20. FILED 9-3- 1939 Paulo Le du MD
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-3- 1939

22. I HEREBY CERTIFY, That I attended deceased from 9-1- 1939, to 9-3- 1939

I last saw him alive on 9-1- 1939. Death is said to have occurred on the date stated above, at 108 m.

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

Mal Nutrition

Other contributory causes of importance:

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 _____, 1939

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? _____

If so, specify _____

(Signed) Paulo Le du MD, M. D.

(Address) Shannon Mo.

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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.

RECEIVED
District Health Officer No. 5,

District File Number 939198

Date Filed 9/13/9

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30364-

Do not use this space.

1. PLACE OF DEATH

- (a) County Shannon Registration District No. 823
(b) Township Shannon Primary Registration District No. _____ Registered No. _____
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(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 Ma May 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 8

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
3 24

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-3 1939

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 m.

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

malnutrition Date of onset

Other contributory causes of importance:

158

Other contributory causes of importance:

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?

If so, specify

(Signed) Frank Hyde, M. D.

(Address) Emmeline

S-30365