

Registration District No. **861**

Primary Registration District No. **6132**

Registrar's No. **1**

1. PLACE OF DEATH:

(a) County **Jacobs**  
(b) City or town **Forsyth**  
(c) Name of hospital or institution  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community  
years, months or days

3. (a) PRINT FULL NAME **Eliza Ann Buchan**  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **W**  
6. (b) Name of husband or wife **David A Buchan**  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased **July 28 1852**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**84** **4** **19** hr. min.

9. Birthplace **Webster Co Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER  
12. Name **Joseph Cornelison**  
13. Birthplace **Donk Know Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary Ann Doak**  
15. Birthplace **Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Joe Engstrom**  
(b) Address **Forsyth Mo**

17. (a) **Walnut Shade** (b) Date thereof (Month) (Day) (Year)  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Walnut Shade**

18. (a) Signature of funeral director **Pa Thornhill**  
(b) Address **Orange Mo**

19. (a) **Dec 17-39** (b) **Gene B Reynolds**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jacobs**  
(c) City or town **Forsyth Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **17th**  
year **1939** hour **8** minute **10** M.

21. I hereby certify that I attended the deceased from **Dec 15th** 1937 to **Dec 17th** 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronch. Pneumonia** Duration **3 days**  
Due to **Pneumonia infection**  
Due to

Other conditions (Include pregnancy within 3 months of death) **10' 10"**

Major findings:  
Of operations  
Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury  
23. Signature **Joe Engstrom** (M. D. or other) **MD**  
Address **Forsyth** Date signed **12-18-39**

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

RECEIVED

District Health Officer No. 6,

City of Chicago, Ill. 240-585

Date Recd. FEB 15 1940

**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.**