

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.

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

6468
Do not use this space.

1. PLACE OF DEATH

(a) County Douglas Registration District No. 272
 (b) Township Finley Primary Registration District No. 5380
 (c) City Ava, Missouri (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.

Registered No. 8

2. PRINT FULL NAME Grace May Buchanan

(a) Residence, No. Ava, Missouri 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				MEDICAL CERTIFICATE OF DEATH	
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>Jan. 15, 1940</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				22. I HEREBY CERTIFY, That I attended deceased from <u>Jan 15, 1940</u> to <u>Jan 15, 1940</u>	
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan. 8-1940</u>				I last saw her alive on <u>Jan 15, 1940</u> Death is said to have occurred on the date stated above, at <u>12:30 a.m.</u>	
7. AGE	YEARS	MONTHS	DAYS	The principal cause of death and related causes of importance were as follows: <u>Bronchial Pneumonia</u> ✓	
			<u>7</u>	Date of onset <u>Death/Injury</u>	
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) <u>Near Ava, Mo.</u>				Other contributory causes of importance:	
FATHER				13. NAME <u>Walter J. Buchanan</u>	
				14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
MOTHER				15. MAIDEN NAME <u>---- -slate</u>	
				16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Douglas Co. Mo</u>	
17. INFORMANT (ADDRESS) <u>Matt. Huffman, Ava, Mo.</u>				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.	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Huffman</u> DATE <u>1-16-40</u> 19__				Manner of injury _____ Nature of injury _____	
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Friends</u>				24. Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify _____ (Signed) <u>Robert M. Norman, M. D.</u> (Address) <u>Ava Mo.</u>	
20. FILED <u>2-26</u> 19 <u>40</u> <u>Henry Buike</u> Local Registrar.					

1072

Dr. RSM. Norman

RECEIVED

District Health Officer No. 6,

District File Number 340-637

Date Filed MAR 5 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 64687

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 272

Primary Registration District No. 5380

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Douglas
(b) City or town Fillley
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

3. (a) PRINT FULL NAME Grace May Buchanan

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min. 7

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 1 day 15 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia

Due to likely to measles or whooping cough
Due to probably from ordinary cold

Other conditions (Include pregnancy within 3 months of death)

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 Robt. M. Narman Address _____ Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

