

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

7606
 Do not use this space.

1. PLACE OF DEATH

(a) County Oregon Registration District No. 633
 (b) Township Thayer Primary Registration District No. 5838 Registered No. 6
 (c) City _____ (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred 7 mos. (If death occurred in Hospital or Institution, write its name instead of street and number) ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 240 Barbara Jean Buckley 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 Fe 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-22-1936
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 3 10 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
 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) Springfield Mo.

FATHER 13. NAME Charles Buckley
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Randolph Co Ark.

MOTHER 15. MAIDEN NAME Lita Clark
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oregon Co Mo

17. INFORMANT (ADDRESS) Charles Clark Thayer Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Myrtle Mo. DATE 3/4-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Low Carr Thayer Mo.

20. FILED 2-14 1940 George Johnson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-12-40
 22. I HEREBY CERTIFY, That I attended deceased from 2-7, 1940, to 2-12, 1940. I last saw her alive on 2-12, 1940. Death is said to have occurred on the date stated above, at 3:50 p. m.
 The principal cause of death and related causes of importance were as follows:

Septicemia Streptococci Date of onset 2-8-40
Streptococci Throat 2-3-40
 Other contributory causes of importance: 115

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) Low Carr M. D.
Thayer Mo. (Address) 56-3

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.

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.