

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 60'SPrimary Registration District No. 4359

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid Co., Mo.
(b) City or town Catron
(If outside city or town limits, write "RURAL" and name of township)(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)In this community _____
years, months or days 153. (a) PRINT FULL NAME Marcella Sue Buchanan

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

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

7. Birth date of deceased 3 25 1940
(Month) (Day) (Year)8. AGE: Years _____ Months _____ Days 4 days If less than one day _____
hr. _____ min. _____9. Birthplace Catron MO.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name David Buchanan13. Birthplace Marion Ky
(City, town, or county) (State or foreign country)14. Maiden name Pearl Rice15. Birthplace Mayfield Ky
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Marcella Buchanan(b) Address Catron MO.17. (a) Burial (b) Date thereof 3 28 40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation New Madrid18. (a) Signature of funeral director None

(b) Address _____

19. (a) 3/28/40 (b) Dr. Husted 534
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid(c) City or town Catron, 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 3/28 day 28 - 1940
year 40 hour _____ minute 30 M.21. I hereby certify that I attended the deceased from 3/25, 1940, to 3/28, 1940that I last saw her alive on 3/28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Failure of tubular foraminelordia to properly close

Due to _____

Due to ISCOther conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Dr. Husted (M. D. or other) _____Address Darma Date signed 3/28

RECEIVED

District Health Officer No. 2

District File

440-948

Date Filed

4/15/40

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.