

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1480

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)

In this community 21 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 514 1/2 East 15th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME LEWIS BUCKLEW 240

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

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

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

7. Birth date of deceased Aug 14 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation City Employee

11. Industry or business Retired

12. Name James Bucklew

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

14. Maiden name Caroline Wray

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

16. (a) Informant's own signature Flores Bucklew

(b) Address 400 East Armour

17. (a) Cremation (b) Date thereof April 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calverwood

18. (a) Signature of funeral director J. W. Wagner

(b) Address 1010 E. 1st

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4th
year 1940 hour 1 minute 30 P M.

21. I hereby certify that I attended the deceased from 3-25-40, 19____, to 4-4-40, 19____; that I last saw h. im alive on 4-4-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death AORTIC ANEURYSM

Due to 9/6

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

Of autopsy None

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 P. H. De Maria (M. D. or other) _____
Address Supt. K. C. Gen. Hospital, K. C. Mo. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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 Cecil R. Watters
Licensed Embalmer No. 3807
P. O. Address K. E. Mo

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.