

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

Do not use this space.

14460

**1. PLACE OF DEATH**  
 County Calloway Registration District No. 107  
 Township 2 Primary Registration District No. 4562  
 City LUXVESSE (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** William Roberts Buckner  
 (a) Residence, No. Luxvesse, Mo. 0 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Male  
**4. COLOR OR RACE** White  
**5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word) Married

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** Margaret Buckner

**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	55	1	16	

**8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.** Farmer & Trader

**9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.**

**10. Date deceased last worked at this occupation (month and year)** Present

**11. Total time (years) spent in this occupation**

**12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Calloway County, Mo.

**13. NAME** Robert Roberts Buckner

**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Calloway County, Mo.

**15. MAIDEN NAME** Ellis Maddox

**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Calloway County, Mo.

**17. INFORMANT** Mrs. W.R. Buckner  
 (ADDRESS) Luxvesse, Mo.

**18. BURIAL, CREMATION, OR REMOVAL** Burial  
 PLACE Luxvesse Cemetery DATE May 17 1940

**19. UNDERTAKER** Hughes Mackin  
 (ADDRESS) Luxvesse, Mo.

**20. FILED** May 16 1940 B. B. Richards  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** May 15, 1940

**22. I HEREBY CERTIFY**, That I attended deceased from December 8, 1939, to Present

I last saw him alive on May 14, 1940. Death is said to have occurred on the date stated above, at 11:15 p.m.

The principal cause of death and related causes of importance were as follows:

/Coronary Occlusion

Date of onset May 15

9412

Other contributory causes of importance:  
 Hqs. Had Rheumatoid Attacks for several years periodically

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

**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?** No

If so, specify \_\_\_\_\_  
 (Signed) X A. H. Dorman, M.D.  
 (Address) Luxvesse, Mo.

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 important.



MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14460

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 102

Primary Registration District No. 4052

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Carthage  
(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 \_\_\_\_\_ 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 Wm Roberts Buesner

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH Month May day 15  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

7. Birth date of deceased March 29 1885  
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>55</u>	<u>1</u>	<u>16</u>	hr. _____ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (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)

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)  
(c) Means of injury \_\_\_\_\_

23. Signatur A. H. Romann M. D. (other) \_\_\_\_\_

Address Carthage Mo Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-14460