

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22539

State File No. _____

Registration District No. 688

Primary Registration District No. 4412

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Frankford Missouri
(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 _____
In this community Life (Specify whether years, months or days)

8. (a) PRINT FULL NAME John Kennedy Bucks

3. (b) If veteran, name war _____ 3. (c) Social Security No. 49718-0640

4. Sex Male 5. Color or race White

6. (b) Name of husband or wife Issbel Richardson

7. Birth date of deceased May 25 1872

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>		<u>17</u>	hr. _____ min. <u>0</u>

9. Birthplace Frankford Mo

10. Usual occupation Shoe Merchant

11. Industry or business _____

MOTHER FATHER {
12. Name John I Bucks
13. Birthplace Ulm Germany
14. Maiden name Ellen Kennedy
15. Birthplace Wreighley Nth Carolina

16. (a) Informant Virginia D Parker

(b) Address Frankford Mo

17. (a) Fairview Cty. (b) Date thereof June 15

(c) Place: burial or cremation Frankford Mo

18. (a) Signature of funeral director Fields and Son

(b) Address Frankford Mo

19. (a) July 2 (b) Mattie Unsell

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike
(c) City or town Frankford
(d) Street No. _____
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13
year 1940 hour 10 minute 30 M.

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

Immediate cause of death Cerebral thrombosis
Dropped dead

Due to _____
Due to 44 10

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? _____
(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 Porter Truman
Address Barling Green, Mo Date signed June 13

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

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

RECEIVED

District Health Officer No. 10

District File Number 7-40-1397

Date Filed JUL 10 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 Low Field Megowan

Licensed Embalmer No. 4093

P. O. Address Frankford, 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.