

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

Registration District No. 801 Primary Registration District No. 4420 State File No. \_\_\_\_\_ Registrar's No. 22

1. PLACE OF DEATH:  
 (a) County Saline  
 (b) City or town Sweet Springs  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Daisy Springs Street  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 26 years (Specify whether years, months or days)  
 In this community 26 years

3. (a) PRINT FULL NAME LUCY C BUIE (D)  
 3. (c) Social Security No. \_\_\_\_\_  
 3. (b) If veteran, name war \_\_\_\_\_ No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, married  
 6. (b) Name of husband or wife Benjamin C Buie 6. (c) Age of husband or wife if alive 82 years  
 7. Birth date of deceased July 10 1863  
 (Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Arrow Rock Saline County Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation House Wife - Retired

11. Industry or business \_\_\_\_\_  
 12. Name Wilber Remington  
 13. Birthplace North Carolina  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Hazel E. Elgin  
 15. Birthplace Virginia  
 (City, town, or county) (State or foreign country)

16. (a) Informant John H. Remington  
 (b) Address Kansas City Mo  
 17. (a) \_\_\_\_\_ (b) Date thereof July 31 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery  
 18. (a) Signature of funeral director Leslett Arvey  
 (b) Address Sweet Springs Mo

19. (a) 7/21/40 (b) R. D. Jones  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Saline  
 (c) City or town Sweet Springs  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Daisy Springs Street  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 30  
 year 1940 hour 12:10 minute PM M. \_\_\_\_\_  
 21. I hereby certify that I attended the deceased from Nov 29  
1939 to July 30 19 40  
 that I last saw her alive on July 30 19 40  
 and that death occurred on the date and hour stated above.

Immediate cause of death Shock  
 Due to Fracture left Hip  
 Due to \_\_\_\_\_  
 Other conditions Sauldity  
 (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) fell out of bed  
 (b) Date of occurrence July 26 1940  
 (c) Where did injury occur? Home Sweet Springs Mo  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Yes (Specify type of place) \_\_\_\_\_  
 While at work? No (e) Means of injury fell out of bed  
 23. Signature Red Charles Parsons (M. D. or other) MD  
 Address Sweet Springs Date signed 7-31-40

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

7  
9  
0

X21492

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 8-13-40

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.....

*Am*  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Joseph Hurley*

Licensed Embalmer No. *2214*

P. O. Address *Sweet Springs*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 26426

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 801

Primary Registration District No. 4430

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Swartz Springs  
(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 \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Lucy C. Buie

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

4. Sex 7 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

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
77 0 20 hr. min.

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

10. Usual occupation.

11. Industry or business.

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)

16. (a) Informant.

(b) Address.

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) 7/31/40 (b) [Signature]  
(Date received by local registrar) (Registrar's signature)

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.

DEATH CERTIFICATION

20. DATE OF DEATH. Month July day 30  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

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

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

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? (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. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

