

Registration District No. 732

Primary Registration District No. 4437

Registrar's No. 732

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Higbee Mo
(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 2
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Higbee 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.

3. (a) PRINT FULL NAME Mrs Roxie Buckler 246

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

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

6. (b) Name of husband or wife Clarence Buckler 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Dec. 14 1897
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 7 10 hr. _____ min.

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

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER { 12. Name Robert Noel
13. Birthplace Howard Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Maggie Cline
15. Birthplace Howard Co Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Buckler
(b) Address Higbee Mo

17. (a) Burial (b) Date thereof July 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fairview

18. (a) Signature of funeral director Joe W Burton
(b) Address Higbee Mo

19. (a) July 25 1940 (b) J. H. Hinn
(Date recorded local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1940 hour 7 minute 45 p. M.

21. I hereby certify that I attended the deceased from June 22 1940
_____ 19____ to July 24 1940
that I last saw her alive on July 24 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure
Due to Uremia
Due to Sub-Acute Nephritis 1940
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
June 22
1940
PHYSICIAN
Underline the cause to which death should be charged statistically.

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)
(e) Means of injury _____

23. Signature W. S. Mendenhall
Address Higbee Mo Date signed 7-25-40

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

X21492

120

RECEIVED

District Health Officer No. 10

District File Number 9-40-1795-

Date Filed SEP 18 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 Harvey S. Robinson

Licensed Embalmer No. 3001

P. O. Address Higbee 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.

Registration District No. **732**

Primary Registration District No. **4437**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Randolph**
(b) City or town **Highlee**
(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 _____
In this community _____ (Specify whether 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) **PROF. FULL NAME** **Mrs. Rosie Buckler**

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

4. Sex **F** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **w**

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 **42** Months **7** Days **10** If less than one day _____ 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

DEATH CERTIFICATION

20. DATE OF DEATH **July 24**
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 **Respiratory failure**
anemia **1930**
Duration _____

Due to **Sub acute nephritis**
kidneys were damaged
during former periods of **hypertension**
Major findings **history of eclampsia**
during former pregnancies
perhaps some permanent damage
to the kidneys

Other conditions (Include pregnancy within 3 months of death) _____
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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

