

FILED JUN 16 1941

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

17918

Do not use this space.

1. PLACE OF DEATH

(a) County Harrison Registration District No. 339
 (b) Township Trail Creek Primary Registration District No. 4202 Registered No. 3 1
 (c) City Mt. Moriah (d) Street No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: Caroline Buckingham

(a) Residence, No. 0 St. 0
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Albert Buckingham

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9/9/1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
74 7 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana13. NAME Stephen Creel14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio15. MAIDEN NAME Racheal Belles16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio17. INFORMANT Harve Buckingham
(ADDRESS) Rodgeway Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Moriah DATE 5/8/194119. FUNERAL DIRECTOR (ADDRESS) Mt. Moriah Mo20. FILED 5/8 1941 Wm. C. Sellers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/7, 1941

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1941, to May 7, 1941
 I last saw her alive on May 7, 1941. Death is said to have occurred on the date stated above, at 7:35 p. m.
 The principal cause of death and related causes of importance were as follows:

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

Cerebral Hemorrhage 5/7/1941
Arteriosclerosis
 Date of onset 5/7/1941

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis? None Was there an autopsy?.....

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) Wm. C. Sellers D. M. D.(Address) Mt. Moriah 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 impor

STATEMENT BY LICENSED EMBALMER

I, J. M. Chambers Licensed Embalmer No. 2109
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Myself
L. E.
No. _____ or by _____ Registered Apprentice No. _____
working under my personal supervision.
Signed J. M. Chambers
Licensed Embalmer No. 2109

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 339

Primary Registration District No. 4202

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town mt mariah
(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)

3. (a) PRINT FULL NAME

Caroline Buckingham

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 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 74 Months 7 Days 28
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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison

(c) City or town Mt. Mariah
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month 5 day 7
year 1947 hour _____ minute _____ M.

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 _____

Duration

Due to _____

Due to _____

Other conditions _____
(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) _____

(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 C. J. Sellers (M. D. or other)

Address mt mariah Date signed _____

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

SUPPLEMENTAL

S-17918