

District No. 89

Primary Registration District No. 5131

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Rombauer
(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 1
In this community 1
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Mauckie Leatrice Buchanan

3. (b) If veteran, name war _____ 3. (c) Social Security No. 1

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Henry Buchanan 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Oct. 3 - 1889
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 3 If less than one day hr. min.

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

10. Usual occupation Farm wife

11. Industry or business _____

12. Name Highway 94mm

13. Birthplace Callaway Co. Mo
(City, town, or county) (State or foreign country)

14. Maiden name Fannie Fadd

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

16. (a) Informant Henry Buchanan

(b) Address Rombauer Mo

17. (a) Burial (b) Date thereof Aug 8 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rombauer Ia Mo

18. (a) Signature of general director Watkins

(b) Address Dexter Mo

19. (a) 8-8-41 (b) Belle Turner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler
(c) City or town Rombauer
(If outside city or town limits, write "RURAL")
(d) Street No. RURAL
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6
year 1941 hour 7 minute 15 P M.

21. I hereby certify that I attended the deceased from July 21, 1941
Present date 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 Lobar Pneumonia
complicated by Influenza

Due to _____

Due to 108

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration

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 J. W. Matthews (M. D. or other) _____

Address Poplar bluff Mo Date signed _____

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

RECEIVED

District Health Office No. 2

District File Number 841-1128

Date Filed 8-15-41

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.....

B. J. Brenzlinger

Licensed Embalmer No. 4201

P. O. Address Peper, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24647
Registrar's No. 311

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 89

Primary Registration District No. 5131

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

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Rombauer 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 _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Maudie G. Buchanan

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 married

(b) Name of husband or wife Henry Buchanan 6. (c) Age of husband, or wife, if alive 54 years

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

8. AGE: Years _____ Months _____ Days _____ 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) _____

(Burial, cremation, or removal) _____ (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-20-41 (b) Belle Kinne
(Date received 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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH. Month _____ day _____ year _____ 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 _____

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) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

