

FILED OCT 30 1942

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

33929

Do not use this space.

1. PLACE OF DEATH

(a) County **Jackson**
(b) Township **Rt. Osage**
(c) City **Buckner**
(e) Length of residence in city or town where death occurred **40** yrs. mos. ds.

Registration District No. **396 148 48**
Primary Registration District No. **4233 0** Registered No. _____
(d) Street No. **1** (If death occurred in Hospital or Institution, write its name instead of street and number) St.
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mrs. Alice Martin.
(a) Residence, No. **Buckner Missouri** St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mr. Lloyd Martin**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Mar. 15, 1860**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 6 13

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. **her home**
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) **Amanda Ohio /**

FATHER 13. NAME **John D. Ucker**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio /**

MOTHER 15. MAIDEN NAME **Nancy Barr**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio /**

17. INFORMANT (ADDRESS) **Miss Ruth Alice Steele**
Buckner Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE **Burial** DATE **9/30 1942**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **V. M. Rappert**
Buckner Mo.

20. FILED **9/30** 19 **42** **V. M. Rappert**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 28 1942**

22. I HEREBY CERTIFY, That I attended deceased from **June** 19**40**, to **Sept 28**, 19**42**

I last saw her alive on **Sept 28**, 19**42** Death is said to have occurred on the date stated above, at **1:15 PM** m.

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

Hypostatic Pneumonia 3 days (Date of onset)

Other contributory causes of importance:

myocardial degeneration 2 yrs

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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? _____

If so, specify _____

(Signed) **S. W. Higgins** M.D.(Address) **Buckner Mo.**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Cause of death to be stated EXACTLY. PHYSICIANS should state every applicable cause known to them.

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.....

V.M. Reppert
V.M. Reppert

.....
Licensed Embalmer No. **2321**

P. O. Address.....

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.

STANDARD CERTIFICATE OF DEATH

State File No. 33929

Registration District No. 148

Primary Registration District No. 4238

Registrar's No. _____

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Buckner
(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 Abiel Martin
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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March (Month) 15 (Day) 1942 (Year)

8. AGE: Years 82 Months 6 Days 15 If less than one day _____ min.

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

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)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September year 1942 hour _____ minute _____ M.

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

Immediate cause of death myocardial degeneration Duration 3 days
myocardial degeneration
Jackson

Due to _____
Due to _____

Other conditions myocardial degeneration
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 108

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

SUPPLEMENTARY

MOTHER FATHER

S-33929 1942