No 2
17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41015

FILED JAN 15 1943

Registration District No. 2178

Primary Registration District No. 3054

Registrar's No.

1. PLACE OF DEATH:

(a) County: Pike

(b) City or town: Louisiana (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 321 N 4th St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DEACESED:

(a) State: Mo (b) County: Pike 82

(c) City or town: Clarksville (If outside city or town limits, write "RURAL") n

(d) Street No. ..... (If rural, give location) 0

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Kate McConkey Buchanan

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: Widow

6. (b) Name of husband or wife .....

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

7. Birth date of deceased: Jany (Month) 16 (Day) 1864 (Year)

8. AGE: Years 78 Months 11 Days 8 If less than one day ..... hr. ..... min.

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

10. Usual occupation: House Keeper

11. Industry or business .....

FATHER

12. Name: James McConkey

13. Birthplace: Don't know (City, town, or county) Va (State or foreign country)

MOTHER

14. Maiden name: Betty Fenny

15. Birthplace: Clarksville (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Mrs. Bode Duncan

(b) Address: 321 N. 4th Louisiana, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 26 42 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenwood

18. (a) Signature of funeral director: Harry Barrow

(b) Address: Clarksville Mo

19. (a) 12-24-42 (Date received local registrar) (b) J. C. Hacy (Registrar's signature)

1169

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 24 year: 1942 hour: 630 minute: A.M.

21. I hereby certify that I attended the deceased from Nov. 23, 1942 to 12/24/42, 19..; that I last saw h.. alive on 12/23/42, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 wk
Due to: Hypertension	1
Due to: Arterio Sclerosis	12
Other conditions: Acute Uremia (Include pregnancy within 3 months of death)	2 days

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature: Robert Gillenders M.D. (M. D. or other)

Address: Louisiana, Mo. Date signed: 12/24/42

(Licensed Embalmer's Statement on Reverse Side)

Definite Arterial Sclerosis

RECEIVED
District Health Officer No. 10
District File Number 1-43-112
Date Filed Jan-13-1943

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~~ me, Registered Apprentice No. 3917 working under my personal supervision.

Signed Ronald A Yahnke

Licensed Embalmer No. 3917

P. O. Address Elsburg

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4615

Registration District No. 218 Primary Registration District No. 3054 Registrar's No.

1. PLACE OF DEATH:
(a) County: Pike
(b) City or town: Louisiana
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Kate M 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: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Jan (Month) 16 (Day) 1864 (Year)
8. AGE: Years 78 Months 4 Days 8 If less than one day min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 24 year 1942 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.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 mo
Due to: Hypertension	1 yr
Due to: arteriosclerosis	30
Other conditions: acute uremia (Include pregnancy within 3 months of death)	2 days

Major findings: Following acute
Of operations: nephritis incident to Cerebral Hemorrhage
Of autopsy: (CEREBRAL HEMORRHAGE)

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury

23. Signature: Robert L. Redline M.D. (M.D. or other)
Address: Louisiana Mo. Date signed 7/11/43

SUPPLEMENTARY