No. 2
—5-42
—17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

2422 ✓

State File No. .....

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 34

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 9725 Winner Road /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson 0

(c) City or town Blue township 0
(If outside city or town limits, write "RURAL")

(d) Street No. 9725 Winner Road
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME William Buxton

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male 0

5. Color or race Wh.

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Carrie B. Buxton

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Jan (Month) 30 (Day) 1879 (Year)

8. AGE: 63 Years | Months 7 | Days I | If less than one day ..... hr. ..... min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation .....

11. Industry or business Real Estate Salesman

FATHER
12. Name Marion Buxton
13. Birthplace Mo. (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Calesta Tyler
15. Birthplace ..... (City, town, or county) Ky. / (State or foreign country)

16. (a) Informant Carrie B. Buxton

(b) Address 9725 Winner Road

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 2, 43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address 918 Brooklyn K.C. Mo.

19. (a) 2-1-1943 (Date received local registrar) (b) James W Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31 year 43 hour 2:10 minute PM M.

21. I hereby certify that I attended the deceased from on 1-27- 1943 to ....., 19....; that I last saw him alive on 1-27-43 ....., 19....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Nephritis ✓	
Due to apoplexy	
Due to Cerebral hemorrhage	
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? ..... (Specify type of place)

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

23. Signature Lewis E. Soper (M. D. or other) DO

Address 11106 Winner Rd Date signed 2-1-43

(Licensed Embalmer's Statement on Reverse Side)

Dr. Lewis Soper
11106 Hunter Rd
Ch. 3688
7 Pm.

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.....

working under my personal supervision.

Signed C. H. Wise

Licensed Embalmer No. 2570

P. O. Address Rc 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, 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. 2422

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 34

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural
(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)

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 Wm. Buxton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 Jan (Month) 30 (Day) 1879 (Year)

8. AGE: Years 63 Months 7 Days 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 Jan day 31
year 1943 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 Nephritis ✓ Complicated by arterial sclerosis resulting in heart failure

Due to apoplexy

Due to cerebral hemmorhage

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 131a

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)
(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY