

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18739

State File No. _____

JUN 1 1948

Registration District No. 290

Primary Registration District No. 5993

Registrar's No. (22) 62

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Fort Leonard Wood, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Station Hospital Cullen
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days (Specify whether
In this community 1 month 3 days
years, months or days)

3. (a) PRINT
FULL NAMEROYCE E. BUCHHOLZ (Pvt)

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased July 8 1924
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
18 10 0 _____ hr. _____ min.

9. Birthplace Kingston Wisconsin
(City, town, or county) (State or foreign country)

10. Usual occupation Soldier-U. S. Army-36813734

11. Industry or business Med. Det 291st Inf.

MOTHER FATHER { 12. Name Edward Buchholz
13. Birthplace Unknown Unknown 4
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) Removal (b) Date thereof May 10, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dalton Wisconsin

18. (a) Signature of funeral director Null & Son Funeral Home

(b) Address 508 West 8th Rolla Missouri

19. (a) May 8 1948 (b) Roberta Murray Major
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wisconsin (b) County Milwaukee 999
(c) City or town Milwaukee
(If outside city or town limits, write "RURAL")
(d) Street No. 3016 West Mt. Vernon Ave. 47
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1948 hour 9 minute 30 A.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 Pulmonary embolism,
bilateral.

Duration

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

As above.

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

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 Roberta Murray Major (M.D. or other)

Address Rolla, Mo. Date signed May 8 1948

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

Embalmer's Statement on Reverse Side

RECEIVED

Pulaski County Health Officer

File Number 5-43-61

Date Filed 5-28-43

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

Licensed Embalmer No.

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 290

Primary Registration District No. 0983

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Fort Leonard
(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

Royce E. Buckholz

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex M 5. Color of W 6. (a) Single, widowed, married,
divorced S

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

7. Birth date of deceased July 8
(Month) (Day) (Year)

8. AGE: Years 18 Months 10 Days 0 If less than one day
min.

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

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 MILITARY RECORDS

(b) Address FORT LEONARD WOOD MO.

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) 6-12-1443 (b) (Signature)
(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 March
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I saw him/her 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)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

S-18739