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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 11 1945

Registration District No. 199

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 40011

Registrar's No. 5323

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Northeast Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2½ days (Specify whether years, months or days)

In this community Yes 8 Years 6 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Independence 4
(If outside city or town limits, write "RURAL")

(d) Street No. 920 South Main 4
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME CORWIN K. BUCHANAN

3. (b) If veteran, name war

3. (c) Social Security No. 491-24-6401

4. Sex Male 0

5. Color or race White

6. (a) ~~Single, widowed~~, married, divorced Married 1

6. (b) Name of ~~husband~~ or wife Maud May Buchanan

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased February (Month) 22 (Day) 1889 (Year)

8. AGE:	Years	Months	Days	If less than one day
~~55~~	55	10	6	hr. min.

9. Birthplace Ringold County, Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation House Mover

11. Industry or business Own

FATHER
12. Name Millard F. Buchanan
13. Birthplace Homesville Ohio 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Ann Cornell Buchanan
15. Birthplace Homesville Ohio 1
(City, town, or county) (State or foreign country)

16. (a) Informant Lois Buchanan Kavorinos

(b) Address 920 So. Main, Indep., Mo.

17. (a) Burial (Burial, ~~cremation,~~ or removal) (b) Date thereof Dec 30-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Inn Mo

18. (a) Signature of funeral director Ott E. Mitchell

(b) Address 310 N. Main St Independence Mo

19. (a) 12-29-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 28 year 1944 hour 4:45 minute P.M. M.

21. I hereby certify that I attended the deceased from Dec 14, 1944, to Dec 28, 1944, that I last saw him alive on Dec 28, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism with acute edema of Lungs. — Duration 12 hrs.

Due to Hypertrophy of the Prostate — about 2 years

Due to

Other conditions (Include pregnancy within 3 months of death) 111a

Major findings: Of operations Prostatectomy. Prostatic Hypertrophy.

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 C. A. Sovlovich (M. ~~or~~ other) DO

Address 1116 Chambers Bldg Date signed 12-29-44

(Licensed Embalmer's Statement on Reverse Side)

K C Mo

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 Henry D. Mitchell

Licensed Embalmer No. 3925

P. O. Address Lindep. 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.