

No. 2
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11031

State File No.

FILED MAY 12 1945

Registration District No. 218

Primary Registration District No. 1003

Registrar's No. 3829

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community..... (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 (12)

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 605 Clara Avenue 9
(If rural, give location)

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

3. (a) PRINT William D. Buchanan
FULL NAME

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Jessie C. Buchanan

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased March 20, 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>1</u>	<u>9</u>	hr. _____ min. _____

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

10. Usual occupation Principal

11. Industry or business Gundlach School

12. Name Wm. James Buchanan

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

14. Maiden name Mary Grey

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

16. (a) Informant Mrs. William B. Buchanan

(b) Address 605 Clara Avenue.

17. (a) Cremation (b) Date thereof May 1, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Shepard Tom Haney

(b) Address 1167 Hamilton Avenue.

19. (a) APR 30 1945
(Date registered) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29, 1945
year 6 hour 30 minute A M.

21. I hereby certify that I attended the deceased from 9/27
4/3 to 4/29, 1945

that I last saw h. a alive on 4/28, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chen Infarctus Myocarditis 4/28/45
(nephritis)

Due to Bright's disease, Chr

Due to _____

Other conditions Myocarditis since 4/27/45
(Include pregnancy within _____ months of death)

Major findings:
Of operations 1/31

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature D. C. Ford (M. D. or other) 7/29
Address University Club Bldg Date signed 7/30/45

APR 30 1945

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

DE 1531

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..... *W Wilkin*

Licensed Embalmer No..... *3575*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 720
Registrar's No. 38219

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(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 Wm D. Buchanan

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 mar 20 (Month) (Day) (Year)

8. AGE: Years 66 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Ohio (City, town, or county) (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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) MAY 18 1945 (Date received local registrar's certificate) J. F. Brueck (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 April Day 9 year 1945 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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? _____

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

11051