

**FILED** JAN 14 1946

Registration District No. **324**

Primary Registration District No. **372**

Registrar's No. **191**

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 835 N. Odell  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 7 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline  
(c) City or town Marshall  
(If outside city or town limits, write "RURAL")  
(d) Street No. 835 N. Odell  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BERNARDINA BUCHANAN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Vance Price Buchanan 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased: Dec - 10 1888  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>11</u>	<u>18</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Henry Vorwerk

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

14. Maiden name Agnes Herzig

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

16. (a) Informant Vance P. Buchanan

(b) Address Marshall mo

17. (a) Burial (b) Date thereof 11-30-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smart Memorial Gardens Marshall mo

18. (a) Signature of funeral director Harry Hershberger

(b) Address Marshall mo

19. (a) 12/5/45 (b) Mrs T.O. Wootch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from held  
request Nov. 28 - 1945

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death

Suicide

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**ADDITIONAL  
SUPPLEMENTARY  
INFORMATION**

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)

(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 Saline

23. Signature P.L. Lawlor Coroner (M. D. or other) \_\_\_\_\_

Address Marshall mo Date signed 12-5-45

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-11-46

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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 \_\_\_\_\_

*Harry Hershberger*

Licensed Embalmer No. \_\_\_\_\_

4357

P. O. Address \_\_\_\_\_

Marshall 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.**

Registration District No. 324

Primary Registration District No. 3072

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Bernardina 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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Dec 10 (Month) (Day) (Year)

8. AGE: Years 56 Months 4 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

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 \_\_\_\_\_

(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) \_\_\_\_\_ (b) \_\_\_\_\_ (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Suicide by Hanging.

Due to Body of was found suspended from the room door with an

ice to ironing card secured with

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external cause, fill in the following: \_\_\_\_\_

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

(b) Date of occurrence Nov. 28, 1940

(c) Where did injury occur? Her home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Marshall Mo. Saline Co.

While at work? Home (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature P. L. Lawless Coroner (M. D. or other) Saline Co.

Address Marshall Mo Date signed 12-7-46

**SUPPLEMENTARY**

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

42558