DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 3 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30984

Registration District No. 211 Primary Registration District No. 5778 Registrar's No. 9-46

1. PLACE OF DEATH:
(a) County Miller-
(b) City or town RURAL - Jim Henry -
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or Institution:
2 mi So Eugene !
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miller- 66
(c) City or town RURAL 0
(If outside city or town limits, write "RURAL")
(d) Street No. 2 mi So Eugene 0
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No) 0
If yes, name country —

3. (a) PRINT FULL NAME Nancy-Elizabeth-Buster-
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Female 5. Color or race White 6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ Widowed
6. (b) Name of husband or ~~wife~~ Monroe Buster-
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Oct (Month) 4 (Day) 1860 (Year)

8. AGE: Years 85 Months 9 Days 5 If less than one day hr. min.

9. Birthplace Miller- Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation House-wife
11. Industry or business At - Home
FATHER 12. Name Issac Wright !
13. Birthplace unknown (City, town, or county) Ky (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace Miller - Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant Gladys Henley
(b) Address Eugene Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July-10-46 (Month) (Day) (Year)
(c) Place: burial or cremation Eugene - Cem
18. (a) Signature of funeral director Ruth McKaye
(b) Address Eldon
19. (a) 7-10-46 (Date received local registrar) (b) Mrs. Richard L. Wright (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9 year 1946 hour 9 minute 50 A.M.
21. I hereby certify that I attended the deceased from June 26, 19 46, to July 9, 19 46, that I last saw h. alive on June 28, 19 46 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	1 day
Due to: Bed ridden from Fractured Hip	15 days
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 66
(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 2
23. Signature M. E. Humphreys (M.D. or other) D.O.
Address Tuscumbia - Mo Date signed 7/10/46

191 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number
Date Filed 10-3-46

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 Keith M Kay

Licensed Embalmer No. 3998

P. O. Address Eldon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. oct

Registration District No. 211 Primary Registration District No. 5778 Registrar's No. 9-46

1. PLACE OF DEATH:

(a) County Miller

(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 Nancy E. Buster

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 wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 4 (Day) 1860 (Year)

8. AGE: Years 85 Months 9 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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 Day 9
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia 2 day

Due to Broken hip

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 1867

Of autopsy 18

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) accident

(b) Date of occurrence

(c) Where did injury occur? Eugene, Miller, Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home
(Specify type of place)

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

23. Signature M. E. Humphrey (M. D. or other) D.O.

Address Tuscumbia, Mo. Date signed

SUPPLEMENTARY

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

29865

30984