

FILED JAN 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3481

State File No. \_\_\_\_\_

Registration District No. 3/7

Primary Registration District No. 6076

Registrar's No. 140

1. PLACE OF DEATH: St. Louis

(a) County Ballwin

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

(c) Name of hospital or institution:  
Pine Crest Nursing Home

(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 Carrie Buckner

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 Tom Buckner

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

7. Birth date of deceased July 12th, 1868  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	6	22	hr. _____ min.

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

10. Usual occupation Housework

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

12. Name Jim Christian

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

14. Maiden name Unknown

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

16. (a) Informant Riley Bell

(b) Address 1291 Hodiament Ave.

17. (a) Burial (b) Date thereof 1-22-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Ce.

18. (a) Signature of funeral director Suedmeyer & Sons.

(b) Address 974 N. 20th. St.

19. (a) 1-23-47 (b) Ruth G. Allen  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 1291 Hodiament Ave.  
(If rural, give location)

(e) Citizen of foreign country? 15 (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19  
year 1947 hour 6.40 minute P M.

21. I hereby certify that I attended the deceased from Dec 12 1947  
to Jan 19 1947  
that I last saw her alive on Jan 17 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Semibody chronic myocarditis

Due to 93D

Due to generalized arteriosclerosis

Other conditions (Include pregnancy within 3 months of death) 93D

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)

(c) Means of injury \_\_\_\_\_

23. Signature a. L. Werber M.D. (M. D. \_\_\_\_\_)

Address 3507 Polomee Date signed 1-24-47

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

MOTHER FATHER

Dr. Martelin  
462 N. Taylor  
1:30 P.M.

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 G. G. Smithers

Licensed Embalmer No. 3916

P. O. Address 3934 N. 20 St

**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.**