

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11181  
Registrar's No. 136

Registration District No. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3901 McMaster Ave 1  
(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 Charles R. Buchard  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Ella 6. (c) Age of husband or wife if alive 25 years  
7. Birth date of deceased January 19, 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 2 4 hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

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

12. Name Joseph Buchanan  
13. Birthplace Hannibal, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Nancy English  
15. Birthplace Georgia  
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Buchanan  
(b) Address 3901 McMaster Ave Hannibal Mo

17. (a) Burial (b) Date thereof March 26, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Ben Terey

18. (a) Signature of funeral director James O'Donnell

(b) Address Hannibal Mo

19. (a) Apr 29 47 (b) W E M Luke  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Marion 64  
(c) City or town Hannibal 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3901 McMaster Ave 4  
(If rural, give location) 0  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23 year 1947 hour \_\_\_\_\_ minute 7:30 a.m.

21. I hereby certify that I attended the deceased from Jan 19, 1947 to March 23, 1947  
that I last saw him alive on March 20, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis  
Due to hypertension  
Due to atherosclerosis

Duration
?
?
?
?

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 0

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Signature] Date signed \_\_\_\_\_

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

9-2  
45  
-39  
47070

MOTHER FATHER

**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. 497  
working under my personal supervision.

Signed H. M. McConnell

Licensed Embalmer No. 3889

P. O. Address Stannett 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.**