

Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **Mo. Methodist Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 days**
(Specify whether Life)
 In this community **Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Buchanan**
 (c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1632 Frederick Ave.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Harry T. Buckner**
 (b) If veteran, **No** name war _____
 3. (c) Social Security No. **491-10-3184**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **October** day **6**
 year **1947** hour **8** minute **30** P. M.

4. Sex **Male**
 5. Color or race **White**
 6. (a) Single, widowed, married, divorced, **widowed**
 6. (b) Name of husband or wife **Clara Buckner**
 6. (c) Age of husband or wife if alive **20** years **1880**
 7. Birth date of deceased **March 20 1880**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10.2.47**, 19____, to **10.6.47**, 19____;
 that I last saw him alive on **10.6.47**, 19____;
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
J	67	6	16	hr. _____ min. _____

Immediate cause of death **Pulmonary embolism**
 Due to **Ch. thrombotic emboli**
 Duration **1 hr.**
4 yrs

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)
 10. Usual occupation **East Side Body Works**
Automobile

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

11. Industry or business **James Buckner**
 12. Name _____
 13. Birthplace **Indianapolis Indiana**
(City, town, or county) (State or foreign country)
 14. Maiden name **Martha Culp**
 15. Birthplace **Gentry County Missouri**
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause of which death should be charged statistically.

16. (a) Informant **Joe Branham**
 (b) Address **St. Joseph, Mo.**
 17. (a) **Burial** (b) Date thereof **10/7/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
Ashland Cemetery
 (c) Place: burial or cremation _____

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? _____
(Specify type of place)
 While at work? _____ (e) Means of injury _____

18. (a) Signature of funeral director **Neaton Bowman**
 (b) Address **St. Joseph, Mo.**
 19. (a) **10-9-47** (b) **E. C. Jenkins**
(Date received local registrar) (Registrar's Signature)

23. Signature **E. C. Jenkins** (M. D. or other) _____
 Address **St. Joseph, Mo.** Date signed **10.6.47**

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

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.....

James B. Hawkins..... Registered Apprentice No. *27*
working under my personal supervision.

Signed..... *Eugene Wood*

Licensed Embalmer No. *3804*

P. O. Address *319 So. 10th, St. Joseph, 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.