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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31046**
Registrar's No. _____

FILED OCT 14 1947

Registration District No. 172

Primary Registration District No. 4221

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Mountain View, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether
In this community 34 Years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town Mountain View, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James M. Buchanan

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

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

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

7. Birth date of deceased (Month) (Day) (Year) 1876

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

9. Birthplace Carter County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

12. Name Samuel Buchanan

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

14. Maiden name Not Known

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant J.G. Buchanan

(b) Address Wynne Ark

17. (a) Burial (b) Date (Month) (Day) (Year) Sept 26 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wynne Ark

18. (a) Signature of funeral director Funeral Home

(b) Address Mountain View, Mo

19. (a) 10-4-1947 (b) Laura Metcalf
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept, day 23rd
year 1947 hour 3 minute B 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 Angina Pectoris Duration _____

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Major findings: 44B
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 3

23. Signature Maime C. Thornburgh (M.D. or other Coroner)
Address West Plains, Mo. Date signed 10/2/47

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

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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

.....
working under my personal supervision.

Registered Apprentice No.

Signed Joe R. Amman

Licensed Embalmer No. 4325

P. O. Address Montevideo, Minn.

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.