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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31121
Registrar's No. 4165

Registration District No. 779 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 1 day years, months or days)

3. (a) PRINT FULL NAME FRANKIE MARY BUCKLE
3. (b) If veteran, name war no 3. (c) Social Security No. 486-07-6995

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 21 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 11 11 hr. min.

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

10. Usual occupation Clerk

11. Industry or business K.C. Life Insurance Co.

12. Name William Buckle
13. Birthplace (unknown) Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Dora Briggs
15. Birthplace (unknown) Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Pebley

(b) Address 1860 North 27th St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-4-1947
(Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery, Lebo, Kans.

18. (a) Signature of funeral director Geo. H. Lang
(b) Address 703 North 10th Street

19. (a) 10-3-47 (b) Shiraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1860 North 27th Street
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2
year 1947 hour 9 minute 30 A.M.

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

Immediate cause of death Acute Coronary dilatation & heart failure

Due to Aortic stenosis & calcification
Adverse CA of ulcers

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy fatal

Duration _____
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 J. C. [illegible] (M. D. or other)
Address St. Luke's Hospital Date signed _____

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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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Louis A. Long

Licensed Embalmer No. *3417*

P. O. Address.....

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.