

No. 307
A-10-47
7-5-17-39
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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37059**

FILED NOV 23 1948

Registration District No. **157**

Primary Registration District No. **3028**

Registrar's No. **251**

49

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

1. PLACE OF DEATH:

(a) County **Jasper**

(b) City or town **Carthage**

(c) Name of hospital or institution: **McCune Brooks Hospital**
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **5 Days**
(Specify whether years, months or days)

In this community **10 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** **49**

(c) City or town **Carthage**
(If outside city or town limits, write "RURAL")

(d) Street No. **123 So. Main** **3**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **None**

3. (a) PRINT FULL NAME **Leona Clotell BUELL**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **8th**, year **1948** hour **4:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **5-19-48** to **11-7-48**, 19___, to ___ 19___; that I last saw her alive on **11-7-48**, 19___; and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **John R. Buell**

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

7. Birth date of deceased **April 17, 1863**
(Month) (Day) (Year)

Duration **5 days**

Due to **Chronic nephritis** **3 yrs**

Due to _____

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

85 **6** **21** hr. min.

Other conditions **Chronic arterio-sclerotic cardio-vascular disease.** **10 yrs**
(Include pregnancy within 3 months of death)

9. Birthplace **Princeton, Mo.** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

Major findings: **131B**

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business **None**

12. Name **Joseph Mason** **9**

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

14. Maiden name **Mary Mulvaney** **9**

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

16. (a) Informant **Mrs. Florence Heistand**

(b) Address **Okla. City, Oklahoma.**

17. (a) **Burial** (b) Date thereof **11-9-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fairview Cemetery**

18. (a) Signature of funeral director **Ed. C. Ulmer**

(b) Address **Carthage, Mo.**

19. (a) **11-9-1948** (b) **L. B. Clenton**
(Date received local registrar) (Registrar's signature)

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? **0**

While at work? _____ (Specify type of place)

(e) Means of injury _____

Signature **L. B. Clenton** (M. D. or other) **11/8/48**
Address **374 Grant St., Carthage** Date signed

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 *John S. Penneby*
Licensed Embalmer No. *4194*
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.