

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27174

State File No. _____
Registrar's No. 870

FILED AUG 25 1952

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH a. COUNTY Buchanan 0117		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan 0117	
b. CITY (If outside corporate limits, write RURAL and give township) St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph 0	
c. LENGTH OF STAY (in this place) 1 day		d. STREET ADDRESS (If rural, give location) Hillcrest Apts.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital			

3. NAME OF DECEASED (Type or Print) Dorothy E. Buzard			4. DATE OF DEATH (Month) (Day) (Year) August 12, 1952		
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5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced ?		8. DATE OF BIRTH February 17, 1904		9. AGE (In years last birthday) 48		IF UNDER 1 YEAR Months Days		IF UNDER 6 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) purchasing agent				10b. KIND OF BUSINESS OR INDUSTRY chemical company				11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri				12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME George M. Buzard		13b. MOTHER'S MAIDEN NAME Mamie R. Hood		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 10		16. SOCIAL SECURITY NO. 491-09-3029		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lawrence Buzard, 1822 Howard, St. Joseph, Mo	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 3 mo	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Renovascular disease</i>					
		ANTECEDENT CAUSES					
		DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death. <i>Anaphylactic Shock from Novoline</i>				Instances <i>Instantaneous</i>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from *1 Aug 1952*, to *17 Aug 1952*, that I last saw the deceased alive on *12 Aug 1952*, and that death occurred at *8 A.M.*, from the causes and on the date stated above.

23a. SIGNATURE <i>D. Phillips</i>		(Degree or title) <i>M.D.</i>		23b. ADDRESS <i>St. Joseph Mo</i>		23c. DATE SIGNED <i>8.12.52</i>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		24b. DATE <i>8/14/1952</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>St. Joseph Missouri</i>	
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DATE REC'D BY LOCAL REG. <i>Aug 21, 1952</i>		REGISTRAR'S SIGNATURE <i>Carl C. Casby</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Bowman</i>		ADDRESS <i>Funeral Home</i>	
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(Licensed Embalmer's Statement on Reverse Side)

St. Joseph, Mo.

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed *William Spalding*

Licensed Embalmer No. *4535*

P. O. Address *319 S. 10th St. Jackson, 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.

William Spalding
Embalmer