

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19237**
Registrar's No. **4531**

FILED MAY 18 1953

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4431 S. Broadway		d. STREET ADDRESS (If rural, give location) 15 4431 S. Broadway	
3. NAME OF DECEASED (Type or Print) AGNES S BUCKLAND		4. DATE OF DEATH (Month) (Day) (Year) MAY 3 1953	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH March 7, 1872
9. AGE (In years last birthday) 81	10. KIND OF BUSINESS OR INDUSTRY NA	11. BIRTHPLACE (State or foreign country) Liberty, Missouri	
12. CITIZEN OF WHAT COUNTRY? U		13a. FATHER'S NAME Bernard Spencer	
13b. MOTHER'S MAIDEN NAME Susan Spencer		14. NAME OF HUSBAND OR WIFE Thomas A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Linda McCormack		ADDRESS 311 Stark Court	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Webster Groves, Mo.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INSUFFICIENCY		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension		2 years	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION no	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 443X			
22. I hereby certify that I attended the deceased from Feb , 1951, to May 3 , 1953, that I last saw the deceased alive on MAY 1 , 1953, and that death occurred at 3 A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Chas E. Handman M.D.		23b. ADDRESS 320 Washington	
23c. DATE SIGNED May 3 1953			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-5-53	
24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAY 4 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Hoffmeister Colonial Mortuary		ADDRESS 6464 Chippewa	

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Harry J. Schumacher

Signed.....
Student Embalmer

Licensed Embalmer No. *2679*

P. O. Address

7814 J. Broadway

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.