No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5367

BIRTH NO. FILED MAR 1 1954 REG. DIST. NO. 385 PRIMARY REG. DIST. NO. 3039 Registrar's No. 3

1. PLACE OF DEATH
a. COUNTY: Linn
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marceline, Mo
c. LENGTH OF STAY (In this place): 1
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Francis Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Linn
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): StCatherine,
d. STREET ADDRESS (If rural, give location): R. 2

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) JAMES c. (Last) BUCKLEY
4. DATE OF DEATH (Month) 1 (Day) 29 (Year) 54
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 7/27/77
9. AGE (In years last birthday): 76 — If under 1 year: Months 6, Days 2; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Freight Agt
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): St. Catherine
12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME: Cornelius Buckley
13b. MOTHER'S MAIDEN NAME: Hanora Powers
14. NAME OF HUSBAND OR WIFE: Rose Riley Buckley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Rose Buckley ADDRESS: St. Catherine, Mo

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Carcinoma Prostate C Metastases
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: 177X
20. AUTOPSY? YES ☐ NO ☐

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1953, *to* 1-28, 1954, *that I last saw the deceased alive on* 1-28, 1954, *and that death occurred at* 10:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] (Degree or title): MD
23b. ADDRESS: Marceline, Mo
23c. DATE SIGNED: 1-30-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Feb. 1. 54
24c. NAME OF CEMETERY OR CREMATORY: St. Michael
24d. LOCATION (City, town, or county) (State): Brookfield, Mo

DATE REC'D BY LOCAL REG.: 1-30-54
REGISTRAR'S SIGNATURE: Mary Jane Rodgers 401
25. FUNERAL DIRECTOR'S SIGNATURE: James W. McLaughlin ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

MAR 2

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 George L. Trumbell

Licensed Embalmer No. 4425

P. O. Address 600 E. Santa Fe Marceline, 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.