

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 17 1954

17094  
State File No. 4112  
Registrar's No. 4112

BIRTH NO. \_\_\_\_\_ 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	
b. CITY (If outside corporate limits, write RURAL and give town) St Louis		c. CITY OR TOWN St Louis	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4417a Laclede		e. STREET ADDRESS (If rural, give location) 4417a Laclede	

3. NAME OF DECEASED (Type or Print)	a. (First) Frances	b. (Middle) Sarah	c. (Last) Buckler	4. DATE OF DEATH (Month) (Day) (Year) May 4, 1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH Nov 12, 1882	9. AGE (In years last birthday) 71	10 UNDER 1 YEAR Months	11 UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Frazier	13b. MOTHER'S MAIDEN NAME Gingrich	14. NAME OF HUSBAND OR WIFE Everett Buckler
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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) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME B F Buckler	ADDRESS 5412 Walsh
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis DUE TO (c) Cerebral Apoplexy		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 4222
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22. I hereby certify that I attended the deceased from 4-30-54, 19, to 5-4-54, 19, that I last saw the deceased alive on 5-4-54, 19, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE <i>Robert K. Smith</i> (Degree or title) D.C.	23b. ADDRESS 3407 S. Grand Blvd.,	23c. DATE SIGNED 5-5-54
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 5/8/54	24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	24d. LOCATION (City, town, or county) (State) Mexico, Mo.
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DATE REC'D BY LOCAL REG. MAY 7 1954	REGISTRAR'S SIGNATURE <i>Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons	ADDRESS 7027 Gravois
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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.....  
Signature of Student Embalmer

Signed *E. P. Kidwell*

Licensed Embalmer No. *387*

P. O. Address *7027 Gra*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.