

FILED JAN 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43094

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 185

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Scott</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sikeston</b>		c. CITY OR TOWN <b>Sikeston</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>15 Minutes</b>		e. STREET ADDRESS (If rural, give location) <b>518 S. Kingshighway</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Delta Community Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Orillo</b>	b. (Middle) <b>-----</b>	c. (Last) <b>Buchanan</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>12 17 1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12-2-1877</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 4 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Golconda, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Frank King, Decd.</b>	13b. MOTHER'S MAIDEN NAME <b>Amanda Flanery, Decd.</b>	14. NAME OF HUSBAND OR WIFE <b>Charles C. Buchanan, Decd.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>0</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Amos Buchanan, Cape Girardeau, Mo.</b>	ADDRESS
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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) <b>Myocardial heart disease</b>		<b>?</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Hypertensive Cardiovascular D.</b> DUE TO (c)		<b>?</b>
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) m.	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 **March, 1954**, to **Dec. 17, 1954**, that I last saw the deceased alive on **12/17**, 1954, and that death occurred at **10:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Wm. C. Critchlow</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Sikeston, Mo.</b>	23c. DATE SIGNED <b>Dec. 20, 1954</b>
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24a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>12-19-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>	24d. LOCATION (City, town, or county) (State) <b>SIKESTON MO</b>
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DATE REC'D BY LOCAL REG. <b>12-29-54</b>	REGISTRAR'S SIGNATURE <b>Mrs. Ella Hunter</b>	424-0	25. FUNERAL DIRECTOR'S SIGNATURE <b>Welch Funeral Home - Sikeston Mo</b>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

203  
0

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DATE RECEIVED JAN 3 1955  
SCOTT CO. HEALTH DEPT.  
CO. FILE No. 155-3

OCT  
8 1957  
MAY 2 1955

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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 Raymond Grews

Licensed Embalmer No. 346

P. O. Address Sebastian

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.