

FILED JAN 17 1955 THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 5125 Registrar's No. 22

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Rural Center Twp.)
c. LENGTH OF STAY (In this place) 50 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION R.F.D. # 6, St. Joseph, Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Buchanan
c. CITY-OR TOWN Rural (Center)
d. Is Residence within limits of a city or incorporated town? Yes No
e. STREET ADDRESS (If rural, give location) R.F.D. # 6, St. Joseph

3. NAME OF DECEASED (Type or Print)
a. (First) BUCKLIN b. (Middle) _____ c. (Last) DARRELL
4. DATE OF DEATH (Month) (Day) (Year) Jan. 9 1955

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH January 1859 9. AGE (In years last birthday) Abt. 95 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gunsmith
10b. KIND OF BUSINESS OR INDUSTRY Own shop
11. BIRTHPLACE (City and State or Foreign Country) Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE Sadie Darrell

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. None
17. INFORMANT'S SIGNATURE OR NAME Alberta Wilson ADDRESS R.F.D. # 6, St. Jos., Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
INTERVAL BETWEEN ONSET AND DEATH 5 years

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 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.) 500
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 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 Jan 2 - 1955 to Jan. 9th 1955, that I last saw the deceased alive on Jan. 8th 1955, and that death occurred at 12:15 A. m., from the causes and on the date stated above.

23a. SIGNATURE John G. Swails M.D. (Degree or title) 23b. ADDRESS Wathens Kane 23c. DATE SIGNED 1-12-1955

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 1-12-1955 24c. NAME OF CEMETERY OR CREMATORY Moxley Cemetery 24d. LOCATION (City, town, or county) (State) Boston, Missouri

DATE REC'D BY LOCAL REG. Jan 13, 1955 REGISTRAR'S SIGNATURE Kathleen M. Allison 5. FUNERAL DIRECTOR'S SIGNATURE John Rupp ADDRESS St. Joseph, Mo.
(Licensed Embalmer) (Statement on Reverse Side)

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..... *John E. Rupp*
Licensed Embalmer No. 390

P. O. Address..... *St. Joseph*

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.