

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21124**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **725**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived). If institution: residence before admission. a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> <b>0117</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b> <b>0</b>	c. LENGTH OF STAY (In this place) <b>30 Yrs</b>	c. CITY OR TOWN <b>St. Joseph</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <b>0</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>819 South 18th Street</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			
a. (First) <b>Nellie</b>	b. (Middle) <b>Abigale</b>	c. (Last) <b>Buster</b>	<b>July 14th 1955</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b> <b>2</b>	8. DATE OF BIRTH <b>Jan. 3rd, 1881</b>	9. AGE (In years last birthday) <b>74 Yrs</b>	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
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>at home.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Plattsburg, Missouri.</b> <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>Felix View</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Harbett C. Buster</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Theodore R. Buster, (son)</b> CITY ADDRESS <b>3121 So. 29th</b>

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>4200</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7/13**, 19 **55**, to **7/14**, 19 **55**, that I last saw the deceased alive on **7/14**, 19 **55**, and that death occurred at **1:30p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Allan Sherman M. D.</b>	23b. ADDRESS <b>706 Francis, St. Joseph, Mo.</b>	23c. DATE SIGNED <b>7/18/55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>(Burial)</b>	24b. DATE <b>July 16-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>
		24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri.</b>

DATE REC'D BY LOCAL REG <b>July 20, 1955</b>	REGISTRAR'S SIGNATURE <b>Cather M. Allison</b>	485 - 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Allison's Funeral Home, St. Joseph, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

0.48

**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 H. Marsh*

Licensed Embalmer No..... 441

P. O. Address..... St. Joseph,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.