

FILED NOV 16 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35316

STATE FILE NUMBER

318

1003

9431

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT IN HOSPITAL, give location) HOSPITAL OR INSTITUTION Veterans Hosp.			Length of stay in 1b Abt. 20 hrs		d. STREET ADDRESS 4054 Page Blvd.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last William C. Buchanan				4. DATE OF DEATH Month Day Year Oct. 13, 1956			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1898	
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min. 6 26		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurants	
11. BIRTHPLACE (City and state or country) St. Louis, Mo.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Clarence Buchanan				14. MOTHER'S MAIDEN NAME Mamie Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. War 2		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Clara Gibson 4054 Page Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis of Lung;							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Appendectomy;							
DUE TO (c) Anesthesia;							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) following operation performed at					551X
20c. TIME OF INJURY. Hour Month, Day, Year 11:30 p. m. 10-12-56		Veteran's Hospital and October 12th 1956 about 11:30 p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hosp		20f. CITY, TOWN, OR LOCATION St Louis Mo		STATE	
21. I attended the deceased from _____ to _____ and last saw her him _____ Death occurred at 700 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Earl Smith</i> (Degree or title) 3			22b. ADDRESS 1300 Clark			22c. DATE SIGNED 10/16/56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Oct. 17, 1956	23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) Jefferson Barracks, Mo.		
24. FUNERAL DIRECTOR G. Wade Granberry 4202 Finney			25. DATE RECD. BY LOCAL REG. OCT 16 1956		26. REGISTRAR'S SIGNATURE <i>Earl Smith MD</i>		

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. No standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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..... *Melvin E. Green*

Licensed Embalmer No. *44*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitute's 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.