

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 6 1958

STATE FILE NUMBER **2709**
REGISTRAR'S NO. **913**

Registration District No. **318** Primary Registration District No. **1003**

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		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 01 3902 W. Bell			Length of stay in lb	STREET ADDRESS 2119 3902 W. Bell			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First American Middle Last Buchanan				4. DATE OF DEATH Month 1- Day 24- Year 58			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 27-1885		9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houswife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Miss		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Sam Ownes				14. MOTHER'S MAIDEN NAME Unkown			
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. No		17. INFORMANT Address Allen Buchanan 3902 W-Bell		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer (Cancer) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Diabetes Diabetes) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input 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.) 174X				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21: I attended the deceased from 1/20/58 to 1/25/58 and last saw her/him alive on 1/24/58 Death occurred at 1-30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE W.C. Bridges M.D.				22b. ADDRESS 941 N. Sarah		22c. DATE SIGNED 1-25-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/30/58	23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) (State) St. Louis County Mo		
24. FUNERAL DIRECTOR ADDRESS Boyd Bros 3706 Finney Ave			25. DATE RECD. BY LOCAL REG. JAN 25 '58		26. REGISTRAR'S SIGNATURE Carl Smith M.D.		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Annie Bridges, wife of Allen Buchanan

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 *Henry C. Williams*

Licensed Embalmer No. 4781

P. O. Address 1205 Walto

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