

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035339**

FILED VS. NOV 16 1959

REG. NO. A-1570

3007

Registrar's No. 524

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>WAYNE</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>			Length of stay in lb <b>11 DAYS</b>		c. CITY OR TOWN <b>PATTERSON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>NONE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>STOCKARD</b> Last <b>BUCK</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>9-21-92</b>	
				9. AGE (last birthday) <b>67</b>		IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>WELDING</b>		11. BIRTHPLACE (City and state or country) <b>CHAONIA, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>WESLEY BUCK</b>			13b. MOTHER'S MAIDEN NAME <b>SUSAN CHILDERS</b>			14. NAME OF HUSBAND OR WIFE <b>NOT APPLICABLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT <b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		Month, Day, Year					
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	
<b>VA</b>		<b>October 22, 1959</b>		<b>November 2, 1959</b>			
21. I attended the deceased from <b>October 22, 1959</b> to <b>November 2, 1959</b> and last saw him <b>her</b> on <b>November 2, 1959</b> . Death occurred at <b>12:20 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Robert S. Cohen</b> (Degree or title) <b>ROBERT S. COHEN, M.D., Chief, Medical Svc. VA Hospital, Poplar Bluff, Mo.</b>				22b. ADDRESS		22c. DATE SIGNED <b>11-4-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-4-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Veterans Plot</b>		23d. LOCATION (City, town, or county) (State) <b>Poplar Bluff, Mo.</b>		
24. FUNERAL DIRECTOR <b>Frank-Cotrell Poplar Bluff, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>10/6/59</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE OF DEATH: \_\_\_\_\_ PLACE OF DEATH: \_\_\_\_\_

1. NAME OF DECEASED: \_\_\_\_\_ SEX: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

PLACE OF INTERMENT: \_\_\_\_\_

NAME OF EMBALMER: \_\_\_\_\_

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 Charles E. Mung  
X  
Ovi

Licensed Embalmer No. 487  
P. O. Address Opelan B

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.