

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002225

FILED VS FEB 8 1967

Registration No. 209 Primary Registration District No. 3043 Registrar's No. 32

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY MARION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HANNIBAL	Length of stay in 1b 3 days	c. CITY OR TOWN FRANKFORD	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LEVERING HOSPITAL		d. STREET ADDRESS (if outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First KENNEDY Middle STRATTON Last BUCKS			4. DATE OF DEATH Month JAN Day 21 Year 1966			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH APR. 3 1901	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORK ORDER CLERK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) FRANKFORD, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME JOHN K. BUCKS		13b. MOTHER'S MAIDEN NAME ISABELLE RICHARDSON		14. NAME OF HUSBAND OR WIFE RUBY BUCKS	
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.		17. INFORMANT Address MRS. RUBY BUCKS FRANKFORD Mo	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 3 days
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		
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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

21. I attended the deceased from **18 Jan 1961** to **21 Jan 1961** and last saw her/him alive on **21 Jan 1961**
Death occurred at **8:45 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wyneth Hamlin M.D. (Degree or title)	22b. ADDRESS Hannibal mo	22c. DATE SIGNED 1/27/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE JAN 23-1961	23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEM.	23d. LOCATION (City, town, or county) (State) FRANKFORD, Mo.
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24. FUNERAL DIRECTOR ADDRESS MEGOWN FUN'L. HOME FRANKFORD Mo.	25. DATE RECD. BY LOCAL REG. 1/25/61	26. REGISTRAR'S SIGNATURE Dr. E.M. Lucke by William M. Zeman
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 *Jone Fields Megawon*

Licensed Embalmer No. 4093

P. O. Address *Freshford Mo.*

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.