

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041420

STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 188

AMENDED

FILED DEC 4 1961

1. PLACE OF DEATH a. COUNTY <u>JASPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>JASPER</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webb City</u> Length of stay in lb <u>16 yrs</u>		c. CITY OR TOWN <u>Webb City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JANE CHINN Hosp</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside give location) <u>608 No. Tom.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>ANDREW JACKSON BUCHER</u> First Middle Last			4. DATE OF DEATH <u>11-19-1961</u> Month Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-1899</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>0</u> Days <u>25</u> Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u>	11. BIRTHPLACE (City and state or country) <u>JANE, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S</u>	

13a. FATHER'S NAME <u>TOM BUCHER</u>	13b. MOTHER'S MAIDEN NAME <u>FANNIE GIDEON</u>	14. NAME OF HUSBAND OR WIFE <u>BERNICE BUCHER</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war of dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>BERNICE BUCHER 608-N. Tom Webb</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>
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"/> N. <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 _____ 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 At time of death only and last saw her alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C.M. Pence</u> (Degree or title) <u>D.O.</u>	22b. ADDRESS <u>Carterville, Mo</u>	22c. DATE SIGNED <u>11-20-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TRACY CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ANDERSON, Mo. Mo</u>
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24. FUNERAL DIRECTOR <u>Humphrey & Saw 7 Home</u> ADDRESS <u>ANDERSON, Mo. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-27-61</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Madeline Switzer</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

STATE OF MISSOURI

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 Wayne A. Howard

Licensed Embalmer No. 5272

P. O. Address Nail, 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.