

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Hampton  
APR 25 1934

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

PLACE OF DEATH  
County Henry Registration District No. 347 File No. 12646  
Township \_\_\_\_\_ Primary Registration District No. 3018 Registered No. 46  
City Clinton Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Harvey Newton Buchanan  
(a) Residence, No. 219 W Wilson Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE Mrs. H. N. Buchanan  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 11 1859  
7. AGE YEARS 74 MONTHS 10 DAYS 20 If LESS than 1 day, hrs. or min.  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Carpenter  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana  
13. NAME Geo Thomas Buchanan  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know  
15. MAIDEN NAME Elizabeth Glaze  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know  
17. INFORMANT (ADDRESS) Mrs. H. N. Buchanan  
18. BURIAL, CREMATION, OR REMOVAL PLACE Englewood DATE April 3 1934  
19. UNDERTAKER (ADDRESS) Spore Son  
20. FILED 412 34 J. R. Hampton Registrar.

MEDICAL CERTIFICATE OF DEATH

2. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-1 1934  
22. I HEREBY CERTIFY, That I attended deceased from 3-29, 1934, to 4-1, 1934  
I last saw him alive on 4-1, 1934. Death is said to have occurred on the date stated above, at 8:45 a.m.  
The principal cause of death and related causes of importance were as follows:  
Arteriosclerosis of Aorta Date of onset 3-29-34  
Arterial Sclerosis General  
Other contributory causes of importance:  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Chemical Was there an autopsy? No  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_ (Signed) J. R. Hampton, M. D.  
(Address) Clinton Mo.

... should be carefully supplied.  
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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Henry

Registration District No. 347

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 3018

Registered No. 46

City Clinton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Harvey Newton Buchanan

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4 7 19 34

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_. I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The principal cause of death, and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

apoplexy cerebral  
Date of onset 3-29-34

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance: swell

13. NAME

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

Nature of injury \_\_\_\_\_

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. UNDERTAKER (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

20. FILED 4-3 1934 J. B. Haupt Registrar.

(Address) \_\_\_\_\_

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

N. S. BOARD OF HEALTH. DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should be consulted. AGE should be stated. FULLY SUPPLIED. OCCUPATION is very important.

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