

S. No. 2
M-5-42
v. 5-17-39
2-1 X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JUL 10 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23151

State File No.

Registration District No. 353

Primary Registration District No. 6195

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Boone
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Eliza Thompson Buckner

3. (b) If veteran, name war L 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced, single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 5, 1862
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Hunter Post, TX
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or Business _____

12. Name Sarah Buckner

13. Birthplace Ky
(City, town, or county) (State or foreign country)

14. Maiden name Melba Blankenship

15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant JR Buckner

(b) Address Hunter Post, TX

17. (a) Burial (b) Date thereof 6-26-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mitchell Cemetery

18. (a) Signature of funeral director Smith & Ferguson

(b) Address Licking, MO

19. (a) 6-14-47 (b) Edna Nesse
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State TX (b) County Texas
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 11th New Licking
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 25
year 1947 hour 9 minute 0 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to Apr 25, 1947
that I last saw him alive on Apr 10, 1947
and that death occurred on the date and hour stated above.
Immediate cause of death Chronic nephritis Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Lester Fairhall (M. D. or other) _____

Address Licking, TX Date signed 4-30-47

RECEIVED

District Office No. 5,

District File Number 747347

Date Filed 7-8-47

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.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed

Embert E Ferguson

Licensed Embalmer No.

3945

P. O. Address

Licking 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 this body is not embalmed, fact should be so stated above.