

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

Do not use this space.

11159

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis* (No. *4344 Page Ave.*)

File No.....
Registered No. **3196** (Ward)

2. FULL NAME *Rush Esther Buchanan*

(a) Residence. No. *4344 Page Ave.* St., *11* 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

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 28 1912*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
17 9 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *at home*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Missouri*
(STATE OR COUNTRY)

10. NAME OF FATHER *John Buchanan*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis Missouri*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Clara H. Long*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis Missouri*
(STATE OR COUNTRY)

14. INFORMANT *Mrs. Clara H. Long*
(Address) *4344 Page Ave.*

15. FILED **3** & **19** *Max Staker* REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 29 1930*

17. *No Physician in attendance*
I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... *9:45 P.M.*

195 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot wound of head (self inflicted)
(duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) *Whether accidental or intentional not ascertained*
(duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY *No*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *J. W. Kerney M.D.*

5/5/30 (address) *St. Charles*

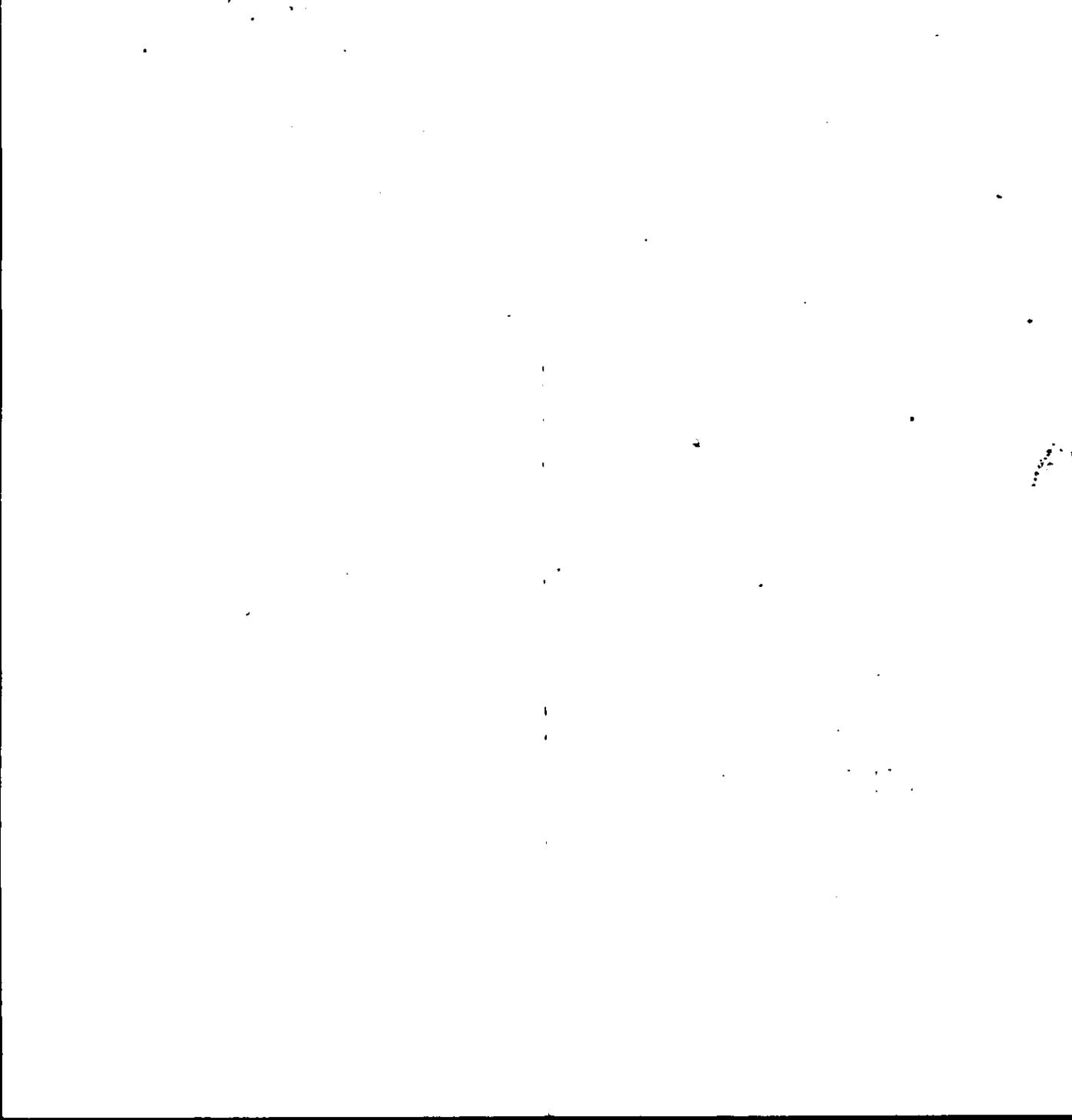
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

St. Peter's Cemetery *4-1 1930*

20. UNDERTAKER ADDRESS
Geo. L. Pleitsch 5966 Eastern Ave.

PARENTS



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ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

486

1. PLACE OF DEATH.

County..... Registration District No. 791 File No. 111591
 Township..... Primary Registration District No. 1003 Registered No. 3196
 City St. Louis (No.) St. Ward)

2. FULL NAME

Ruth Esther Buchanan

(a) Residence. No. St. 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 ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) 8

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT
 (Address) Mrs C Parker

15. X AUG 16 1930 Mrs C Parker REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 29 1930

17. I HEREBY CERTIFY, That I attended deceased from to
 (that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot wound of head, self inflicted
Occurred at Residence

CONTRIBUTORY (SECONDARY) whether accidental or intentional not ascertained

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) J. W. Ferner, M.D.

8/15/30 (Address) Dep. Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

6511-5