

1947 [RECUAN 30 1939]

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

44922  
Do not use this space.

1. PLACE OF DEATH

(a) County Vernon 3 Registration District No. 875  
(b) Township Washington 1 Primary Registration District No. 6162  
(c) City Nevada (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 308

2. PRINT FULL NAME

2414 CHARLES. Buckles  
(a) Residence, No. Greene County Home Springfield, Mo. St.   
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15, 1876

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.  
63 5 22

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as 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) Illinois 1

FATHER 13. NAME Aaron Dow Buckles. 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia 0

MOTHER 15. MAIDEN NAME Caroline Bowers.

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

17. INFORMANT State Hospital No 3 Records.  
(ADDRESS) Nevada, MO

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Springfield, Mo DATE Dec 22, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Thorne Funeral Home  
Springfield, Mo.

20. FILED Dec 20, 1939 Allen Z. Hays  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 24th, 1939, to Dec 20th, 1939  
I last saw h. i. a. alive on Dec 20th, 1939. Death is said to have occurred on the date stated above, at 5 P. m.

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

Lobar Pneumonia (Bilateral)  
108  
Date of onset \_\_\_\_\_  
Other contributory causes of importance:  
Hypertrophy of Heart &  
Ch. Myocarditis.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? clinical Was there an autopsy? yes

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) E. S. WARRICH \_\_\_\_\_, M. D.  
(Address) State Hospital No 3  
Nevada, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X18003

RECEIVED

District Health Officer No. 7,

District File Number 7-40-16

Date Filed A-8-40

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**