

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

3056
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547

(b) Township Mason Primary Registration District No. 3079

(c) City Hannibal (d) Street No. 2001 Garden Registered No. 9

(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.

2. PRINT FULL NAME Benjamin Buckner 256

(a) Residence, No. 2001 Garden St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Col

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-14-1864

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

75 1 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Jahner

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)

FATHER 13. NAME Benjamin Buckner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo 5

MOTHER 15. MAIDEN NAME no Record 0

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

17. INFORMANT (ADDRESS) Mrs Jennie Buckner 2001 Garden

18. BURIAL, CREMATION, OR REMOVAL PLACE Robinson DATE 12-16 1939

19. FUNERAL DIRECTOR (ADDRESS) Geo E Roberts Hannibal, Mo

20. FILED Jan 10 1940 W.C. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-13 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 10 1939, to Dec 12-39, 1939

I last saw him alive on Dec 12-39, 1939 Death is said to have occurred on the date stated above, at 6:30 P.M.

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

Serious Apoplexy

Senility & Hypertension

Other contributory causes of importance: 181

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 1939

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) W.C. Fisher M. D.

486 (Address) Hannibal 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 X12004

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3052**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Marion**

(b) City or town **Hannibal**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

3. (a) PRIN FULL NAME **Benjamin Buechner**

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex **m**

5. Color or race **col**

6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased
(Month) (Day) (Year)

8. AGE: Years **75** Months **1** Days **0**
If less than one day hr. min.

9. Birthplace **Shelbyville, Mo.**
(City, town, or county) (State or foreign country)?

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **March 26 40** (b) **E. M. Luke**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits write "RURAL")

(d) Street No.....
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month **17** day **13**
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....,
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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 **H. B. McMechan** (M. D. or other)
Address **Hannibal Mo** Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-305b