

FULL APR 27 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10588

Registration District No. 152

Primary Registration District No. 5216

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Rural - Camp Branch
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2 1/2 miles south of East Lynne
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 11 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass

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

(d) Street 2 1/2 miles south of East Lynne
(If rural, give location)

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

8. (a) PRINT FULL NAME Lemanda Ella Buckley 24

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

20. DATE OF DEATH: Month Mar day 17
year 1940 11 hour 00 minute _____ M.

4. Sex Fe 5. Color or race wh 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Owen Buckley 6. (c) Age of husband or wife 72 years

7. Birth date of deceased not 29-1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb-16-1940
~~March 12~~ 1940, to March 12 1940
that I last saw her alive on March 12 1940
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>3</u>	<u>13</u>	hr. _____ min.

Immediate cause of death Carcinoma of Colon

Due to _____

Due to 46

9. Birthplace Strasburg Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Other conditions (include pregnancy within 5 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name Michael Keller

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

14. Maiden name Martha Jane Hendrickson

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Owen Buckley

(b) Address R. # 2 - Harrisonville Mo

17. (a) Rural (b) Date thereof 3-14-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Lee Summit Cem

18. (a) Signature of funeral director Alvin Tom

(b) Address Harrisonville 145

19. (a) 3-13-40 (b) Maggie Stonestreet
(Date received local registrar) (Registrar's signature)

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 J. M. Scott (M. D. or other) _____

Address Harrisonville Mo Date signed Mar 19 1940

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.