

MAY 13 1940

605

435-9

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Gallatinsville
(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 2 (Specify whether

In this community, years, months or days 2-1-1)

3. (a) PRINT FULL NAME James Budard

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Budard 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Aug 28 1894
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 40 If less than one day _____ hr. _____ min.

9. Birthplace Middle Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation Shoemaker

11. Industry or business _____

12. Name Archie Budard

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

14. Maiden name Anna Budard

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

16. (a) Informant's own signature Nov Budard

(b) Address Gallatinsville Mo

17. (a) Burial (b) Date thereof Mar 30 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Portageville

18. (a) Signature of funeral director Portageville Mo

(b) Address Portageville Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Gallatinsville
(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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 30
year 1940 hour 1 minute 20 A.M.

21. I hereby certify that I attended the deceased from 3-30
_____ 1940, to 3-30 _____ 1940

that I last saw him alive on 3-30 _____ 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Abscess of Pt. Lung

Due to Influenza

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

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? _____

23. Signature John H. H. H. (M. D. or other) _____
Address Portageville Mo Date signed 3-30-40

Duration

6 wks

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

RECEIVED

District Health Officer No. _____

District File Number 540-10

Date Filed 5/8/40

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15379**

Registration District No. **605-**

Primary Registration District No. **4359**

Registrar's No.

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Osage 715**
(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
In this community _____ years, months or days)

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.

3. (a) PRINT FULL NAME **James Buford Buell**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

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

8. AGE: **unknown** (at 50 yrs) Years Months Days If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **6-8-40** (Date received local registrar) (b) **Dr. Geo W. Huston** (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **mar** day **30** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw him _____ 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 **John J. Billson** (M. D. or other) _____

Address **Platteville** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

