

JUN 14 1940
Registration District No. 590

Primary Registration District No. 43485788A State File No. Registrar's No.

1. PLACE OF DEATH:

(a) County Montgomery Co.
(b) City or town New Florence, Mo. RFD 3
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Louise 2273
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community About 28 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Henry Buecker, 260

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

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

6. (b) Name of husband or wife Henry Buecker, 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased November 30th - 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 5 9 hr. _____ min.

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

10. Usual occupation Housewife, 6

11. Industry or business 9

MOTHER FATHER { 12. Name Joseph Rebsamen, 1

13. Birthplace Germany, 1
(City, town, or county) (State or foreign country)

14. Maiden name Swikehauser,

15. Birthplace Unknown, 1
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Buecker

(b) Address New Florence, Mo. RFD 3

17. (a) (Burial, cremation, or removal) (b) Date thereof May 12th - 40
(Month) (Day) (Year)

(c) Place: burial or cremation Big Spring, Mo.

18. (a) Signature of funeral director Robert Porter

(b) Address Americus, Mo.

19. (a) May 12 - 1940 (b) Blanche Scholten
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Montgomery,
(c) City or town New Florence, Mo. Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Near Big Spring, Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th
year 1940 hour 6 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 1928, to May 6, 1940

that I last saw her alive on May 6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatation Duration
Rt. Ventricle of Heart 5-6-1940

Due to Dilatation 18 yrs.

Due to Hypertension 6 yrs.

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? 520

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature James O. Helms (M. D. or other) 1

*Address New Florence, Mo. Date signed 5-10-40

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

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 _____

D. B. Baker

Registered Apprentice No. _____

working under my personal supervision.

Signed

D B Baker

Licensed Embalmer No. 3375

P. O. Address Americus, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19062

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 390

Primary Registration District No. 3788A

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Monte Rio
(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 _____
In this community _____ (Specify whether 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) Mrs. Magdalena Buecker
FULL NAME

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.

4. Sex 7 5. Color W 6. (a) Single, widowed, married, divorced 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.

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

Immediate cause of death _____

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

8. AGE: Years 73 Months 5 Days 9 If less than one day _____ h. _____ min.

Due to _____

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

Due to _____

10. Usual occupation _____

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

11. Industry or business _____

Major findings:
Of operations _____

12. Name _____

Of autopsy _____

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

14. Maiden name _____

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

22. If death was due to external causes, fill in the following:

16. (a) Informant _____

(a) Accident, suicide, or homicide (specify) _____

(b) Address _____

(b) Date of occurrence _____

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

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(c) Place: burial or cremation _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

(b) Address _____

23. Signature _____ (M. D. or other) _____

19. (a) May 12-40 (b) Blanche Scholten
(Date received local registrar) (Registrar's signature)

Address _____ Date signed _____

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-19062