

2
3-40
-39
K23159

NOV OCT 11 1940
399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1002

State File No. **31088**

Registrar's No. **3651**

Registration District No. _____

Primary Registration District No. _____

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

1. PLACE OF DEATH: **Jackson**

(a) County: **Kansas City**

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

(c) Name of hospital or institution: **Emerson Apts. Garfield & Linwood**
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME: **Robert M. Buster**

3. (b) If veteran, name war: **None**

3. (c) Social Security No.: **None**

4. Sex: **Male**

5. Color or race: **White**

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

6. (b) Name of husband or wife: **Unknown**

6. (c) Age of husband or wife if alive: **Unknown** years

7. Birth date of deceased: **December 3, 1940**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	59	9	16	hr. min.

9. Birthplace: **Macon County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Dentist**

11. Industry or business: _____

12. Name: **Charles M. Buster**

13. Birthplace: **Howard County Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name: **Sarah E. Nichols**

15. Birthplace: **Macon County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mr. C. G. Buster**

(b) Address: **Macon, Missouri**

17. (a) **Removal** (b) Date thereof: **9/20/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Macon, Missouri**

18. (a) Signature of funeral director: **Mrs. C. L. Forster**

(b) Address: **918 Brooklyn, Kansas City, Mo**

19. (a) **9-19-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Jackson**

(c) City or town: **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No.: **Linwood & Garfield**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **20**
year **1940** hour **12:30** minute _____ M.

21. I hereby certify that I attended the deceased from **12:30 A.M. 9-20-40** to **12:50 A.M. 9-20-40**
that I last saw him alive on **12:45 A.M. 9-20-40** and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Thrombosis**

Due to: _____

Due to: _____

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

Major findings: **94B**

Of operations: _____

Of autopsy: _____

Duration

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury: **1**

23. Signature: **Harry K. Cohen** (M. D. or other) **MD.**

Address: **318 Apple Bell** Date signed: **9-20-40**

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. 1100

working under my personal supervision.

Signed E. H. Neal

Licensed Embalmer No. 2570

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.