

FILED JAN 23 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42113

State File No. _____

Registration District No. 152

Primary Registration District No. 5216

Registrar's No. _____

1. PLACE OF DEATH:

(a) County CASS
 (b) City or town GARDEN CITY, MISSOURI
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
CAMPBELL TWP. RURAL
 (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 MISSOURI (b) County CASS
 (c) City or town GARDEN CITY RURAL
 (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 MARY JANE GRAY BUCHANAN

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 WIDOW6. (b) Name of husband or wife JAMES J. BUCHANAN 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased SEPT. 20, 1890
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
50 3 _____ hr. min.9. Birthplace CHATHAM HILL VIRGINIA
(City, town, or county) (State or foreign country)10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name GEORGE WASHINGTON BUCHANAN18. Birthplace TAZEWELL, VIRGINIA
(City, town, or county) (State or foreign country)14. Maiden name MARY JANE FOX
15. Birthplace BERKSGARDEN, VIRGINIA
(City, town, or county) (State or foreign country)16. (a) Informant WM. C. BUCHANAN
(b) Address GARDEN CITY, MISSOURI17. (a) BURIAL (b) Date thereof 12/22/40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation CLEARFORK CEMETERY18. (a) Signature of funeral director Ruth Kauffman(b) Address GARDEN CITY, MO.19. (a) 12-22-40 (b) Mrs Effie Stone Street
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC? day 20, 1940
year _____ hour 2 A.M. minute _____ M.21. I hereby certify that I attended the deceased from Nov. 1, 1940
to Dec. 19, 1940
that I last saw her alive on Dec. 8th, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Coronary Embolism

Duration

Due to Acute indigestion

Due to _____

Other conditions _____
(Include pregnancy within 9 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? _____

145
While at work? _____
(Specify type of place) (e) Means of injury _____23. Signature Frank B Ellis (M. D. or other) _____Address Garden City, Mo. Date signed 12/20

94-12

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.....

Ruth Kaufman

Licensed Embalmer No. 4001

P. O. Address Garden City, 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 DEATHDEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSState File No. 42113Registration District No. 152Primary Registration District No. 5216

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Cass
 (b) City or town Camp Branch T.P.
 (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)

3. (a) ~~PROXY~~ FULL NAME Margaret Gray Buchanan
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
 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 50 Months 3 Days _____ If less than one day _____ min.

9. Birthplace _____ (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 _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

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

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Dec day 20
 year 1994 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: Acute Indigestion
 Due to: The patient was dead when I arrived, Camp Branch
 Due to: What the exact cause was probably Coronary Embolism
 Other conditions: _____ (Include pregnancy within 3 months of death)

- Major findings: _____

- Of operations: 94 B
 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?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

SUPPLEMENTARY

1940
S-42113