

FILED JUN 13 1944

Registration District No. ....

Primary Registration District No. 5692

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Linn  
 (b) City or town Meadville R.R. Parson Creek  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1/5 Camp  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 (Specify whether  
 In this community 60 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58  
 (c) City or town Meadville Rural 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R.R. #1 0  
 (If rural, give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country 1

3. (a) PRINT FULL NAME Mancy Jane Buckles

3. (b) If veteran, name war 1 3. (c) Social Security No. 1

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widow  
 6. (b) Name of husband or wife Robert Buckles 6. (c) Age of husband or wife if alive, deceased 36 years  
 7. Birth date of deceased April 3rd 1857  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
87 | 1 | 10 | hr. min.

9. Birthplace Edgar Co Illinois  
 (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER  
 12. Name Joseph Langley  
 13. Birthplace Illinois  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Do not know  
 15. Birthplace 9  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. A. Darling

(b) Address Meadville Mo

17. (a) Burial (b) Date thereof May 14 '44  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Meadville Cemetery

18. (a) Signature of funeral director Smiley Funeral Home

(b) Address Wheeling Mo.

19. (a) May 16 1944 (b) Mrs. Uiria Rowland  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13th  
 year 1944 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from May 3  
1944 to May 13 1944  
May 3 to May 13 1944  
 that I last saw her alive on May 13 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial  
infarction

Due to cardiovascular  
renal disease  
 Due to arterio sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
 Of operations no  
 Of autopsy no 12/a

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 0

23. Signature E. J. West (M. D. or other)  
 Address Meadville Date signed 5-13-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Self  
Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Frank L Smiley

Licensed Embalmer No. 470

P. O. Address Wheeling, Md.

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, fact should be so stated above.

Registration District No. \_\_\_\_\_

Primary Registration District No. 5692

1. PLACE OF DEATH:

(a) County Lincoln  
(b) City or town Rural Paris  
(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) PRINT FULL NAME

Nancy Jane Buckler

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 W

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if live \_\_\_\_\_ years

7. Birth date of deceased

April 3 1851  
(Month) (Day) (Year)

8. AGE:

Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Mrs. Vivian Rowland  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 13  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

18522