

S. No. 2  
4-5-43  
5-17-39  
1 X36871

FILED SEP 30 1944 318

STANDARD CERTIFICATE OF DEATH  
1003

State File No. 29171  
8206  
Registrar's No.

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution..... 0 (Specify whether years, months or days)

In this community..... 0 (Specify whether years, months or days)

3. (a) PRINT FULL NAME..... William R. Buchanan

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..... Married

6. (b) Name of husband or wife..... Ada Buchanan

6. (c) Age of husband or wife if alive..... 67 years

7. Birth date of deceased..... August 17 1874  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

70 5 5 hr. min.

9. Birthplace..... Polk County Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation..... Farmer

11. Industry or business.....

12. Name..... Unknown

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

14. Maiden name..... Unknown

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

16. (a) Informant..... Lucian Buchanan

(b) Address..... Chicago, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof..... 9-23-44  
(Month) (Day) (Year)

(c) Place: burial or cremation..... Golconda, Illinois

18. (a) Signature of funeral director..... Albert H. Hoppe

(b) Address..... 4700 Washington Blvd.

19. (a) SEP 26 1944 (Date received local health officer's report) (b) J. R. Bredek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Illinois (b) County..... Polk

(c) City or town..... Golconda  
(If outside city or town limits, write "RURAL")

(d) Street No..... NR  
(If rural, give location)

(e) Citizen of foreign country?..... 2 (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... September day..... 27  
 year..... 1944 hour..... 11 minute..... 12 A.M.

21. I hereby certify that I attended the deceased from..... August 31, 1944, to..... September 27, 1944,  
 that I last saw him alive on..... September 21, 1944,  
 and that death occurred on the date and hour stated above.

Immediate cause of death..... Duodenitis of liver 34 years  
 Due to.....

Due to.....

Other conditions..... 124  
(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..... 0

23. Signature..... Her. H. Taylor (M. D. or other) Date signed..... 9/27/44

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

8206

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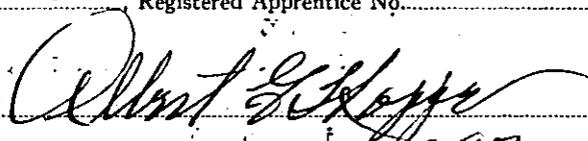
**STATEMENT BY LICENSED EMBALMER**

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. 2971.....

..... 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, fact should be so stated above.**