S. No. 2
DM—5-42
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9638

Registrar's District No. FILED MAR 30 1945

Primary Registration District No. ~~2000~~ 5465

Registrar's No. 222

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural; N. Campbell Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.F.D. # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County GREENE

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

(d) Street No. 304 W. PINE
(If rural, give location)

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

3. (a) PRINT FULL NAME HARRY M. BUCKLEY

3. (b) If veteran, name war NONE

3. (c) Social Security No. 500-10-1345

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MAY BUCKLEY

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased JAN (Month) 10, (Day) 1890 (Year)

8. AGE: Years 55 Months 2 Days 5 If less than one day ..... hr. ..... min.

9. Birthplace BENTON Co. (City, town, or county) MO. (State or foreign country)

10. Usual occupation AUTO MECHANIC

11. Industry or business AUTOMOBILE

MOTHER FATHER

12. Name BOONE BUCKLEY

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

14. Maiden name MARY FEBACK

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

16. (a) Informant Mrs. May Buckley
(b) Address 304 W. Pine, Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 18-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director J. W. Klingner Co.
(b) Address Springfield Mo.

19. (a) 3-17-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 15 year 1945 hour 4 minute 00 P.M.

21. I hereby certify that I attended the deceased from No Physician no attendance 19..; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	
Due to	
Due to: 94th	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Murray C. Stone (M. D. or other)
Address Springfield, Mo. Date signed 3-16-45

(Licensed Embalmer's Statement on Reverse Side)

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.....Mark Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.