

No. 2
8-43
5-17-39
X37823

FILED AUG 19 1948

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 216

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
215 E Missouri
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether)
In this community all her life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 215 E Missouri
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Lois Buhl

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 S
7. Birth date of deceased Mar 8 1865
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days 16 If less than one day hr. _____ min. _____

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

10. Usual occupation Lawyer

11. Industry or business _____

MOTHER FATHER

12. Name Lewis Buhl
13. Birthplace Hubtown MO
(City, town, or county) (State or foreign country)
14. Maiden name Susan Crutchfield
15. Birthplace Hubtown MO
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Harry Salisbury
(b) Address Kirksville MO

17. (a) Burial (b) Date thereof 7-26-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paultown Cem

18. (a) Signature of funeral director Summers Paul
(b) Address Kirksville Mo

19. (a) 7-31-46 (b) State Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1946 hour 1 minute _____ M.
21. I hereby certify that I attended the deceased from Jan - 1945 to July - 2, 1946
that I last saw her alive on July 2, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy
Due to Arterio-Sclerosis
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy 830

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? _____

23. Signature H. B. Harrison (M. D. or other) MD
Address Kirksville Mo Date signed July 23, 1946
(Specify type of place) (e) Means of injury 2

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

RECEIVED
District Health Officer No. 10
District #3 Member #10-1539
Date Filed AUG 14 1946

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: W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Richville

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.