DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 27 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26293

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 950

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether
In this community ~~Life~~ 15 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Clinton 25
(c) City or town Rural Hardin 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME JOSEPHINE CULVER BUCKLEW

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

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife not stated
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 12 (Day) 1877 (Year)

8. AGE: Years 68 Months 9 Days 9 If less than one day hr. min.

9. Birthplace Grayson (City, town, or county) Mo (State or foreign country)
10. Usual occupation House wife
11. Industry or business own home

FATHER
12. Name W. L. Culver
13. Birthplace --- (City, town, or county) Ky (State or foreign country)

MOTHER
14. Maiden name Augusta Virginia Mo Michael
15. Birthplace --- (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs. Howard Thurman
(b) Address Plattsburg Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 46 (Month) (Day) (Year)
(c) Place: burial or cremation Plattsburg - Greenlawn
18. (a) Signature of funeral director Jas L Martin
(b) Address Plattsburg Mo.
19. (a) Aug. 23, 1946 (Date received local registrar) (b) H. Nestlebush (Registrar's signature) By V.N.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 21 day year 1946 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 19, 1946, to Aug 21, 1946 that I last saw her alive on Aug 21, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Liver — Duration ?

Due to Cancer Rt breast — 1941

Due to 6 — 50

Other conditions Cholecystitis (Include pregnancy within 3 months of death) Cholecystitis

Major findings: Of operations Gallbladder Cancer

Of autopsy

PHYSICIAN — Underline 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 H W Carke MD (M.D. or other)
Address St Joseph Mo Date signed 8/22/46

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(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Jak L. Martin

Licensed Embalmer No. 4303

P. O. Address Plattsburg

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 950

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Josephine C. Buchlen
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 Nov 12 (Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec Day 21 year 1946 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to
Carcinoma of right breast ?
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operation
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

26293