

FILED SEP 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30021

State File No. \_\_\_\_\_

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 176

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall, Mo.  
(c) Name of hospital or institution: none  
(d) Length of stay: In hospital or institution no  
In this community 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State No. (b) County Saline 97  
(c) City or town Marshall  
(d) Street No. (If rural, give location) 2  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Franklin Buis

3. (b) If veteran, name war no  
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 Hestir Buis  
6. (c) Age of husband or wife if alive 65 years  
7. Birth date of deceased: Septan 27 1866

8. AGE: Years 80 Months 10 Days 13  
If less than one day hr. min.

9. Birthplace Savannah Mo.

10. Usual occupation retired

11. Industry or business

MOTHER FATHER

12. Name Perry Buis  
13. Birthplace Ind.  
14. Maiden name Mary Dobbs  
15. Birthplace Ind.

16. (a) Informant Mrs. Hestir Buis  
(b) Address State School, Marshall, Mo.

17. (a) Burial (b) Date thereof 8-12-47  
(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director Hill Brothers, Slater, Mo.  
(b) Address

19. (a) Aug 24-47 (b) Sidney J. Gray  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10th  
year 1947 hour 4 minute 30 a. M.

21. I hereby certify that I attended the deceased from April 10, 1947 to Aug 10, 1947  
that I last saw him alive on Aug 9, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease

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

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

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

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(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 James A. Reed (M. D. or other)  
Address Marshall Mo Date signed 8-11-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 9-10-59

VS SEP 29 1959

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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 A. C. Hill

Licensed Embalmer No. 7090

P. O. Address States, Mo.

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.