

FILED JUL 21 1948

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Callaway
 (b) City or town Tulou
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: State Hospital No. 1. 9
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 years
 In this community same (Specify whether years, months or days)

3. (a) PRINT FULL NAME ROBERT BUCKNER.
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race N. 6. (a) Single, widowed, married, divorced M. /

6. (b) Name of husband or wife DK 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: (Month) 2 (Day) 8 (Year) 1902

8. AGE: Years 46 Months 5 Days 3 If less than one day hr. _____ min. _____

9. Birthplace Kentucky (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation laborer

11. Industry or business _____

12. Name Robert Buckner

13. Birthplace D.K (City, town, or county) _____ (State or foreign country) _____

14. Maiden name Sister

15. Birthplace Kentucky (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant Hospital Records

(b) Address Madison Mo.

17. (a) Burial (b) Date thereof July 19-48
 (Burial, cremation, ~~other~~) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director W. Labadie

(b) Address St. Louis, Mo.

19. (a) July 16 48 (b) Jose M. ...
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4414 Maffett St. 17
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION:
 20. DATE OF DEATH: Month 7 day 13
 year 1948 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from 7-10-48, 19____, to 7-13-48, 19____;
 that I last saw him alive on 7-13-48, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia
Septicemic meningitis
emphysema etc.

Due to _____

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

Major findings: Of operations _____
 Of autopsy lobar pneumonia
bilateral

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) _____ (e) Means of injury _____

While at work? _____ (e) Means of injury _____

Signature A.P. Price (M. D. or other) _____
 Address Callow Mo. Date signed 7/16/48

Duration

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. 9,
District File Number
Date Filed JUL 20 1948

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 Eli Bell
..... Licensed Embalmer No. 2130
..... P.O. Address Fulton, 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.