

FILED JAN 24 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

202

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>56</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Buchanan</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>45yrs 1 Mo 5dy</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 2.</u>				d. STREET ADDRESS (If rural, give location) <u>State Hospital #2.</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) <u>BERT</u>		b. (Middle) <u>-</u>		c. (Last) <u>BUCKLEN.</u>		(Month) (Day) (Year) <u>January 9, 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>October 27, 1885</u>	9. AGE (In years less birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Candy maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Candy making</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>? Bucklar</u>		13b. MOTHER'S MAIDEN NAME <u>Greene</u>		14. NAME OF HUSBAND OR WIFE <u>Never Married</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Greene Buckler - 821 N. 9th St. Joseph</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocarditis</u>				<u>5 years</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Psychosis with epilepsy</u>				<u>45 years</u>	
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychosis - Dementia Praecox</u>				<u>45 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph, Buchanan, Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>3-1-1947</u> to <u>1-9-1949</u> , that I last saw the deceased alive on <u>1-8-1949</u> , and that death occurred at <u>7:50 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Honest Thomas M.D.</u>				23b. ADDRESS <u>State Hospital No. 2</u>		23c. DATE SIGNED <u>1-9-1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan. 15, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Savannah Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Savannah, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 15, 1949</u>		REGISTRAR'S SIGNATURE <u>E. L. Einsine</u>		382 0 25. FUNERAL DIRECTOR'S SIGNATURE <u>Hattie Meierhoffer</u>		ADDRESS <u>1946 Colhoun St. St. Joseph, Mo.</u>	

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

By Morroway G. D.

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Albert A. Harrington

Signed _____
Student Embalmer

Licensed Embalmer No. 3258 Missouri.

P. O. Address St. Joseph, 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.