

FILED FEB 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3657

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Saline</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall, Mo</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Marshall township</u>		
c. LENGTH OF STAY (In this place) <u>18 Days</u>			d. STREET ADDRESS (If rural, give location) <u>5 Miles S.W. Marshall</u>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Fitzgibbons Hospital</u>					

3. NAME OF DECEASED (Type or Print) a. (First) <u>Winnie</u> b. (Middle) <u>Neal</u> c. (Last) <u>Buck</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 8th, 1949.</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 6th, 1885.</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 2 HRS. Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Gainesville, Texas.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
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13a. FATHER'S NAME <u>Simon Neal</u>	13b. MOTHER'S MAIDEN NAME <u>Sophonria Barbee</u>	14. NAME OF HUSBAND OR WIFE <u>Francis Darwin Buck</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Francis Darwin Buck, Marshall, Mo.</u>
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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>Intentional Strangulation</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bernice's pneumonia</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Paralytic Illness</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from Jan 8, 1949 to Jan 8, 1949, that I last saw the deceased alive on Jan 8, 1949, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John R. Lawrence, M.D.</u>	23b. ADDRESS <u>Marshall, Mo</u>	23c. DATE SIGNED <u>Jan 10-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 10, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Marshall, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Jan 10-1949</u>	REGISTRAR'S SIGNATURE <u>Sidney T. Gray</u> 385	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>CAMPBELL-Lewis-MARSHALL, Mo.</u>
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(Licensed Embalmers' Statement on Reverse Side)

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

97  
1  
2

RECEIVED

District Health Officer No. 8,

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

Date Filed 2-10-49

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. 263

working under my personal supervision.

Student James H. Lewis  
Student Embalmer

Signed Bill Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall, W. Va.

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.