

FILED NOV 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33002**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1209

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Joseph) c. LENGTH OF STAY (In this place) 1 hour		c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION Flanagan Nursing Home 2018 Francis Street		d. STREET ADDRESS (If rural, give location) 3227 Renick Street	
3. NAME OF DECEASED (Type or Print) a. (First) Ina b. (Middle) Glendora c. (Last) Buis		4. DATE OF DEATH (Month) (Day) (Year) November 1, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH September 26, 1870
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Rosendale, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Robert Lee Herran		13b. MOTHER'S MAIDEN NAME Mary E. Smith	14. NAME OF HUSBAND OR WIFE Thomas Grant Buis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Myron Coats St. Joseph, Mo.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart, with Acute obclusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis General DUE TO (c) Hypertention, Cerebrovascular Accident	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	INTERVAL BETWEEN ONSET AND DEATH few minutes
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)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?
21e. HOW DID INJURY OCCUR?		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-17, 1949 , to Nov 1, 1949 , that I last saw the deceased alive on Nov 1, 1949 , and that death occurred at 1:45 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE Wm B. Robinson (Degree or title)		23b. ADDRESS 510 Corby Bldg St. Joseph Mo.	23c. DATE SIGNED Nov 2, 1949
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Nov. 4, 1949	24c. NAME OF CEMETERY OR CREMATORY Coffman Cemetery	24d. LOCATION (City, town, or county) (State) Savannah, Missouri.
DATE REC'D BY LOCAL REG. Nov 9, 1949	REGISTRAR'S SIGNATURE E. S. Jenkins	GENERAL DIRECTOR'S SIGNATURE Walter Heierhoffer ADDRESS 1046 Colhoun St. St. Joseph, Mo.	

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.

Student *****
Student Embalmer

Signed Raymond W. Morehead
Licensed Embalmer No. 4413 Missouri

P. O. Address St. Joseph, Missouri.

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.