

FILED MAR 10 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6050

State File No. ....

318

1003

Registrar's No. 18278

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 4 Mo.	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary		d. STREET ADDRESS (If rural, give location) 21 - 3418 Bellave	

3. NAME OF DECEASED (Type or Print) William Buckner			4. DATE OF DEATH (Month) (Day) (Year) Feb. 26, 1950	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 31 1872	9. AGE (In years last birthday) 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ironton Mo.	12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME John Buckner	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Sarah H. Buckner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sarsh H. Buckner 3418 Bellave

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Post tonsillar abscess due to</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Virus infection 4 8 hours</u> DUE TO (c) <u>aspiration pneumonitis 24 hours</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>cardiac failure few hours</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ 12 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Valuer Duane Bowdich</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS City Infirmary	23c. DATE SIGNED 2/26/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/3/50	24c. NAME OF CEMETERY OR CREMATORY ChesterField Mo.
24d. LOCATION (City, town, or county) (State) Chesterfield Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.W. Roberts 1416 N. Taylor ave
DATE REC'D BY LOCAL REG. FEB 27 1950	REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>	

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

**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 Fulton E. Cullkin

Licensed Embalmer No. 4198

P. O. Address Phoenix 137

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.