

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 22 1950

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 34

6273

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

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Cooper</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>Chariton</u> |  |
| b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <u>Boonville, Mo.</u> |  | c. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <u>Keytesville Rural 0220</u>                           |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hosp</u>                                      |  | d. STREET ADDRESS (If rural, give location) <u>RFD No 2.</u>  |  |

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Sidney</u> b. (Middle) <u>Buchanan</u> c. (Last) _____ |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>APR. 8, 1950</u> |  |  |
|---|--|--|---|--|--|

|                 |  |                               |  |  |  |                                      |  |   |  |  |  |   |  |
|-----------------|--|-------------------------------|--|--|--|--------------------------------------|--|---|--|--|--|---|--|
| 5. SEX <u>M</u> |  | 6. COLOR OR RACE <u>negro</u> |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u> |  | 8. DATE OF BIRTH <u>March 5 1875</u> |  | 9. AGE (In years last birthday) <u>75</u> |  | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>8</u> |  | IF UNDER 1 HRS.<br>Hours _____ Min. _____ |  |
|-----------------|--|-------------------------------|--|--|--|--------------------------------------|--|---|--|--|--|---|--|

|   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> |  |  | 11. BIRTHPLACE (State or foreign country) <u>Chariton Co Mo</u> |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|

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|---|--|--|--|--|--|---|--|--|
| 13a. FATHER'S NAME <u>George T Buchanan</u> |  |  | 13b. MOTHER'S MAIDEN NAME <u>Maria Jane Lutheridge</u> |  |  | 14. NAME OF HUSBAND OR WIFE <u>single</u> |  |  |
|---|--|--|--|--|--|---|--|--|

|  |  |                                   |  |  |  |  |  |
|--|--|-----------------------------------|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> |  | 16. SOCIAL SECURITY NO. <u>no</u> |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Talmadge Bushman Keytesville Mo</u> |  |  |  |
|--|--|-----------------------------------|--|--|--|--|--|

|   |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>4-2-50</u> |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |  |  |  |  |  | 33IX   |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>arteriosclerosis</u>           |  |  |  |  |  | 2  |  |

|                                    |  |  |  |  |  |  |  |  |  |
|------------------------------------|--|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION <u>none</u> |  | 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) _____ |  |
|--|--|--|--|--|---|--|

|   |  |  |  |  |  |                                  |  |  |
|---|--|--|--|--|--|----------------------------------|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ |  |  | 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 4-4, 1950, to 4-8, 1950, that I last saw the deceased alive on 4-7, 1950, and that death occurred at 2:25 A.M., from the causes and on the date stated above.

|  |  |                                  |  |                                |  |
|--|--|----------------------------------|--|--------------------------------|--|
| 23a. SIGNATURE (Degree or title) <u>T. C. Beckett MD</u> |  | 23b. ADDRESS <u>Boonville Mo</u> |  | 23c. DATE SIGNED <u>4-8-50</u> |  |
|--|--|----------------------------------|--|--------------------------------|--|

|   |  |                                |  |   |  |  |  |
|---|--|--------------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> |  | 24b. DATE <u>April 11 1950</u> |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant</u> |  | 24d. LOCATION (City, town, or county) (State) <u>near Keytesville Mo</u> |  |
|---|--|--------------------------------|--|---|--|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. <u>April 10 1950</u> |  | REGISTRAR'S SIGNATURE <u>D. Cooper</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gas M. Daugherty, Marsden Mo</u> |  |
|---|--|--|--|--|--|

APR

RECEIVED

OFFICE NO. 2

FILE NO.

FILED 4-21-50

VS  
JUL 23 1959

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 *Blanche M. Langlin*

Licensed Embalmer No. *1989*

P. O. Address *Marceline 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.