

FILED OCT 10 1951

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **31346**
 Registrar's No. **8592**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2257	
d. FULL NAME OF HOSPITAL OR INSTITUTION 615 Walnut St		d. STREET ADDRESS (If rural, give location) 25 615 Walnut St	
3. NAME OF DECEASED (Type or Print) a. (First) Sam b. (Middle) Buchanan c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 9 15 51	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Apr 1904
9. AGE (In years last birthday) 47		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MO		12. CITIZEN OF WHAT COUNTRY? White	
13a. FATHER'S NAME William		13b. MOTHER'S MAIDEN NAME William	
14. NAME OF HUSBAND OR WIFE William			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) William		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH ? ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a.) stating the underlying cause last. DUE TO (b) _____ 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	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? PO2X			
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 8:00 AM. , from the causes and on the date stated above.			
23a. SIGNATURE Wm Henry Reppert, Coroner (Degree or title)		23b. ADDRESS 1300 Olive	
23c. DATE SIGNED 9/24/51			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE SEP 28 1951	
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. SEP 28 1951		REGISTRAR'S SIGNATURE J. Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE W. Rowland		ADDRESS 4104 Manchester	

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

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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 _____

Students of Mortuary College

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *James E. Lammers*

Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

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.