

FILED JUN 24 1954

STANDARD CERTIFICATE OF DEATH

State File No. 20267

No. 300

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5161

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 0		c. CITY OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 3635 Aldine	
3. NAME OF DECEASED (Type or Print) a. (First) Georgia		b. (Middle) Mae	
c. (Last) Buckner		4. DATE OF DEATH (Month) (Day) (Year) June 9, 1954	
5. SEX 3 FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW 2	8. DATE OF BIRTH 7-18-1920
9. AGE (In years last birthday) 33		10. MONTHS	11. BIRTHPLACE (City and State or Foreign Country) MEMPHIS TENN
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY CAFÉ GREY HOUND BUS	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME GEORGE LEIBETTER		13b. MOTHER'S MAIDEN NAME LENA DAVIS	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME LENA HAWKINS 3635 ALDINE	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Hypertension 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 Congestive Heart Failure Arteriolar Nephrosclerosis	
19a. DATE OF OPERATION		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 442X			
22. I hereby certify that I attended the deceased from June 4, 1954, to June 9, 1954, that I last saw the deceased alive on June 9, 1954, and that death occurred at 2:10 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) E. B. Williams, M. D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 6/9/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 6-9-54	
24c. NAME OF CEMETERY OR CREMATORY CAIRO ILL.		24d. LOCATION (City, town, or county) (State) CAIRO ILL.	
DATE REC'D BY LOCAL REG. JUN 9 1954		REGISTRAR'S SIGNATURE Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Bennie Lowe		ADDRESS 3103 Washington	

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *H. Claude Gordon*.....

Licensed Embalmer No. *348*.....

P. O. Address *4575 A*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.