

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 4 1955

State File No. 10457

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 588

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Clayton</b>	c. LENGTH OF STAY (In this place) <b>6 days</b>	c. CITY OR TOWN <b>University City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Co. Hospital</b>		STREET ADDRESS (If rural, give location) <b>12 WELAND AVE.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Mayne</b> b. (Middle) _____ c. (Last) <b>Buckman</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>3 8 55</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 17 1887</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Charles Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>

13a. FATHER'S NAME <b>Steve Lawlar</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Dolan</b>		14. NAME OF HUSBAND OR WIFE <b>Jos. I. Buckman Dec.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Earl E. Buckman 5928 Cote Brillante</b>	

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary, Emboli, - bilateral</b>		
	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. <b>Adeno Carcinoma Pancreas metastatic</b>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>Fract</b>		20. AUTOPSY? <b>465 + H</b> YES <input checked="" 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?	

22. I hereby certify that I attended the deceased from 3-2, 1955, to 3-8, 1955, that I last saw the deceased alive on 3-8, 1955, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Paul W. Lawlar M.D.</b>		(Degree of Title)		23b. ADDRESS <b>601 So. Brentwood</b>		23c. DATE SIGNED <b>3/9/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>3/11/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Barrameo Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Charles Mo.</b>	

DATE REC'D BY LOCAL REG. <b>3-9-55</b>		REGISTRAR'S SIGNATURE <b>Nesbet R. Donk M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Jos. W. Clark 1125 Hodiamont Ave.</b>	
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WRITE PLAINLY—USING UNFADING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *John F. Haines*.....

Licensed Embalmer No. *410*

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