

FILED MAY 25 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17638**
4335

| | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's 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 (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) _____ | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital | | | | e. STREET ADDRESS (If rural, give location) 21 2731 Gamble 22190 | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Jim | | | b. (Middle) _____ | | | c. (Last) Buckingham | | | |
| 4. DATE OF DEATH | | (Month) 4 | | (Day) 30 | | (Year) 56 | | | |
| 5. SEX male | 6. COLOR OR RACE Cold | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | | 8. DATE OF BIRTH Feb 9 5 1984 | | 9. AGE (in years last birthday) 72 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) ABERDEEN MISS. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13a. FATHER'S NAME Rev. Buckingham James Bramlette | | | 13b. MOTHER'S MAIDEN NAME Ollie Buckingham | | | 14. NAME OF HUSBAND OR WIFE _____ | | | |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME Ollie Buckingham ADDRESS 2731 GAMBLE | | | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Prostate with Metastases | | | | INTERVAL BETWEEN ONSET AND DEATH Undt. | |
| ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | DUE TO (c) _____ | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Right Foot - Infected Hernia, Hiatus | | | | 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"/> | | 1774 | | | | | | | |
| 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) _____ | | 21f. HOW DID INJURY OCCUR? _____ | | | |
| 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"/> | | | | | | | |
| 22. I hereby certify that I attended the deceased from 4-16 , 19 56 , to 4-30 , 19 56 , that I last saw the deceased alive on 4-30 , 19 56 , and that death occurred at 11:05p m. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE Frank O. Richards (Degree or title) M.D. | | | | 23b. ADDRESS 2601 N. Whittier | | 23c. DATE SIGNED 5-1-56 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 5-5-1956 | | 24c. NAME OF CEMETERY OR CREMATORY Washington Park | | 24d. LOCATION (City, town, or county) (State) St. Louis MO. | | | |
| DATE REC'D BY LOCAL REG. MAY 3 1956 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE A. L. Beal Und Co. ADDRESS 4303 BELMAR | | | | | |

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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 *Leroy M. Bannister*.....

Licensed Embalmer No. *45*

P. O. Address *3880 East*

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.