

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43349

STATE FILE NUMBER

FILED DEC 30 1957

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 443

1. PLACE OF DEATH a. COUNTY ADAIR		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ADAIR	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KIRKSVILLE		c. CITY OR TOWN KIRKSVILLE 2013	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1510 E. JEFFERSON YRS.		d. STREET ADDRESS (If outside, give location) 1510 E. JEFFERSON	
3. NAME OF DECEASED (Type or print) ANNA MAY BUCKLES		4. DATE OF DEATH DEC. 16, 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (City and state or country) ADAIR COUNTY, Mo.
13. FATHER'S NAME JAMES A. BUOY		14. MOTHER'S MAIDEN NAME CATHERINE LOWE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT ROSCOE W. BUCKLES	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Depression Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Brain tumor - meningioma with sacromatous changes DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Nov 1956 to Dec 16, 1957 and last saw her alive on Dec 13, 1957 Death occurred at 9:32 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE M. T. Hutenshain (Degree or title) DO		22b. ADDRESS Kirksville Mo	
22c. DATE SIGNED 12-27-57		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC. 19, 1957	
23c. NAME OF CEMETERY OR CREMATORY MAPLE HILLS CEMETERY		23d. LOCATION (City, town, or county) (State) ADAIR COUNTY, Mo.	
24. FUNERAL DIRECTOR Davis & Davis ADDRESS KIRKSVILLE, Mo.		25. DATE RECD. BY LOCAL REG. 12-24-1957	
26. REGISTRAR'S SIGNATURE Roscoe W. Ratliff			

JAN 23 1958

JAN 31 1958

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.....
Robert B. Davis

Licensed Embalmer No. *421*

P. O. Address *Kirksville*

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.