

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**45328**

STATE FILE NUMBER

FILED JAN 2 1958

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. 147

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CLARKSVILLE</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP</u>		Length of stay in 1b <u>1 DAY</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH ELLA BUCHANAN</u>			4. DATE OF DEATH Month Day Year <u>DEC 15, 1957</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 11, 1871</u>
9. AGE (In years less birthday) <u>86</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (City and state or country) <u>NEAR-FOLIA, MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>CHAMPNESS T SHAW</u>		13b. MOTHER'S MAIDEN NAME <u>SUSAN ADZONIA HUNTER-ALBERT BUCHANAN</u>	
14. NAME OF HUSBAND OR WIFE <u>MARION LAWRENCE, CLARKSVILLE, MO.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO ONE</u>		17. INFORMANT <u>MARION LAWRENCE, CLARKSVILLE, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>17 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DIS.</u>			<u>18 MO.</u>
DUE TO (c) <u>CORONARY ATHEROSCLEROSIS</u>			<u>UNK.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>SHOCK &amp; CONGESTIVE FAILURE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 (a) or PART II of item 18.) <u>4200</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 <u>MAY 5, 1956</u> to <u>DEC 15, 1957</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>DEC 15, 1957</u> Death occurred at <u>11:30 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>S. Buchanan</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Clarksville</u>	
22c. DATE SIGNED <u>12/24/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC 18, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEM</u>	23d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE, MO</u>
24. FUNERAL DIRECTOR <u>CARROLL-COLLIER, CLARKSVILLE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 24, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Geo. M. Callie*

Licensed Embalmer No. *3839*

P. O. Address *Louisiana*

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.