

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008941  
STATE FILE NUMBER

FILED MAR 31 1959 Registration District No. 104 Primary Registration District No. 4176 Registrar's No. 9

300 4  
-57

1. PLACE OF DEATH a. COUNTY <b>Dunklin</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Malden</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Malden</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Malden</b> <b>0356</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>207 So Taylor</b>		Length of stay in lb <b>19 months</b>	d. STREET ADDRESS (If outside, give location) <b>207 So. Taylor</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>BOBBIE</b> Middle <b>JOE</b> Last <b>BUCKLEY</b>	4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>1959</b>
--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1939</b>	9. AGE (In years last birthday) <b>19</b>	IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>19</b>
--------------------	-------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Parma, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
---	-----------------------------------	--	---

13a. FATHER'S NAME <b>Wayne Buckley</b>	13b. MOTHER'S MAIDEN NAME <b>Melissa Oliver</b>	14. NAME OF HUSBAND OR WIFE <b>Betty Buckley</b>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Betty Buckley, 207 So. Taylor, Malden, Mo</b>	Address
--	---	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immed.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>331X</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Rheumatic Heart Disease</b>		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 or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Malden, Mo</b>	COUNTY <b>Malden</b>	STATE <b>Mo</b>
---	---	--	---	-------------------------	--------------------

21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at <b>2 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>Wayne Cron</b> (Degree or title) <b>MD.</b>	22b. ADDRESS <b>Malden, Mo</b>	22c. DATE SIGNED <b>3-12-59</b>
--	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 11, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Malden, Missouri</b>
--	-----------------------------------	---	--

24. FUNERAL DIRECTOR <b>Landess Funeral Home, Campbell, Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-25-59</b>	26. REGISTRAR'S SIGNATURE <b>J. W. Schuman</b>
---	---------	--	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Christine M. Landess*

Licensed Embalmer No. *4227*

P. O. Address *Campbell, Mo*

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.