

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-029779**

**FILED VS AUG 24 1959**

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 236

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Monroe</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>	Length of stay in 1b ----	c. CITY OR TOWN <b>Monroe City</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Elizabeth Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>112 East Cleveland</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Dorothea</b> Last <b>Buckman</b>			4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1959</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8/7/1959</b>	9. AGE (last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>0</b> Day <b>2</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>Hannibal Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
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13a. FATHER'S NAME <b>Otis Guy Buckman</b>		13b. MOTHER'S MAIDEN NAME <b>Mary C. Bruegenhemke</b>		14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----	16. SOCIAL SECURITY NO. -----	17. INFORMANT Address <b>Otis G. Buckman Monroe City Mo.</b>	
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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>Pulmonary atelectasis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Prematurity</b>	DUE TO (c) <b>Placenta praevia</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)	
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20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b>	Month, Day, Year <b></b>
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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 <b>Hannibal, Missouri</b>	COUNTY <b>Monroe</b>	STATE <b>Missouri</b>
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21. I attended the deceased from **8-7-59** to **8-9-59** and last saw her alive on **8-9-59**  
Death occurred at **12:09 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Frank R. Bures, M.D.</b>		22b. ADDRESS <b>Hannibal, Missouri</b>	22c. DATE SIGNED <b>8-11-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/11/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>	23d. LOCATION (City, town, or county) <b>Shelbina, Mo.</b>
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24. FUNERAL DIRECTOR <b>Harold Garner Monroe City Mo.</b>		ADDRESS <b>8-14-59</b>	25. DATE RECD. BY LOCAL REG. <b>8-14-59</b>	26. REGISTRAR'S SIGNATURE <b>Dr. M. Lucke By W.C. Fisher</b>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *James Turner*

Licensed Embalmer No. 3720

P. O. Address Monroe City M

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.