

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038834

FILED VS NOV 30 1959

STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 5037 Registrar's No. 228

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>Audrain</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico Mo</u> Length of stay in lb <u>33 Months</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Neil Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN <u>New Florence Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>none</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Oda</u> Middle <u>Edward</u> Last <u>Buchanan</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Montgomery Co Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Richard Buchanan</u>			13b. MOTHER'S MAIDEN NAME <u>Eliza Fields</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Lela Buchanan</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT Address <u>Mrs Lela Buchanan New Florence 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 infarct</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Generalized</u>					INTERVAL BETWEEN ONSET AND DEATH <u>two weeks</u> ? years		
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>							
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 <u>2-12-59</u> to <u>11-17-59</u> and last saw <u>him</u> alive on <u>11-17-59</u> Death occurred at <u>11: A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Blanche Neely and co</u>			22b. ADDRESS <u>Superior Inn</u>		22c. DATE SIGNED <u>11-20-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-21-59</u>	23c. NAME OF CEMETERY OR REPOSITORY <u>Wellsville</u>	23d. LOCATION (City, town, or county) <u>Wellsville Mo</u> (State)				
24. FUNERAL DIRECTOR ADDRESS <u>Appelhaus Montgomery City Mo</u>			25. DATE RECD. BY LOCAL REG. <u>Nov 20-1959</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 me
~~XXXX~~ on the 17 th day of Nov 1959 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed C. W. Hopkins
C. W. Hopkins

Licensed Embalmer No. I487
Montgomery City Mo.
P. O. Address _____

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.