

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 8 1960

211707

'59 0 4 5 2 7 6
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

UNRECORDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		a. STATE Illinois	b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		c. CITY OR TOWN Pekin	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b		d. STREET ADDRESS Rt. 32	(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	4. DATE OF DEATH	Month	Day	Year
	CHARLES	NMN	BUCHANAN	DECEMBER	17	1959	

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH — 1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-----------------------	----------------------------------	--	-----------------------------------	-------------------------------------	---------------------------	------------------------	-------	------

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

13a. FATHER'S NAME Francis Buchanan	13b. MOTHER'S MAIDEN NAME Esther Talbott	14. NAME OF HUSBAND OR WIFE Mary Buchanan
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 325-22-4548	17. INFORMANT Kuecks F. Home	Address Pekin, Ill.
---	---	--	-------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH YEARS
IMMEDIATE CAUSE (a)	PULMONARY INSUFFICIENCY	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) PULMONARY ACTIVE/TUBERCULOSIS AND PULMONARY EMPHYSEMA	YEARS
	DUE TO (c) 002x	
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 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. _____	Month, Day, Year
---	------------------

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. 25, 1959** to **DEC. 17, 1959** and last saw her/him alive on **DEC. 17, 1959**
Death occurred at **2:00 a.m.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. E. Lupton, M.D.</i>	(Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 12/17/59
---	-----------------------------------	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/17/59	23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery	23d. LOCATION (City, town, or county) Forest City, Illinois
---	------------------------------	---	---

24. FUNERAL DIRECTOR C. E. Lupton & Sons	ADDRESS 7233 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. DEC 17 1959	26. REG. CLERK'S SIGNATURE <i>Lead Smith, M.D.</i>
--	-------------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JANUARY 1954

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 Clarence N. Drue

Licensed Embalmer No. 409
P. O. Address H. Loeu

Note: The above ~~MUST BE~~ SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.