

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
EILED VS MAR 25 1960

60-012393

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2989** STATE FILE NUMBER _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 4151 Kossuth Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle R. Last Buckman				4. DATE OF DEATH Month March Day 13 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Joseph Buckman			13b. MOTHER'S MAIDEN NAME Sarah Spaulding		14. NAME OF HUSBAND OR WIFE Gladys Buckman		
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. None	17. INFORMANT Address Mary Lou Spica, 4151 Kossuth Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Arterio-sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 331+ DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
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 _____ 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 Jan 1960 , to March 1960 and last saw ^{her} him alive on 2/12/60 Death occurred at 2:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) William O. Mowsey M.D.				22b. ADDRESS 3625 Fair Ave.		22c. DATE SIGNED 3/18/60 (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-15-60	23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		23d. LOCATION (City, town, or county) Monroe City, Mo.			
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. MAR 14 1960		26. REGISTRAR'S SIGNATURE Paul Smith, M.D. <i>W&B</i>		

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 Stanley H. Dixon
Licensed Embalmer No. 419
P. O. Address St. Louis

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.