

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-035831

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No.            Registrar's No. 404

FILED SEP 25 1962

VS 300  
Rev. 4/59

6940

20940

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9493X

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St Francois</b>	
b. CITY (If outside corporate limits give TOWNSHIP only) OR <b>St. Francois Twp.</b> TOWN <b>Farmington Mo -rural</b> Length of stay in lb		c. CITY OR TOWN <b>Farmington</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mineral Area Hosp.</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>RFD # 2</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <b>William Wesley Buchanan</b>			4. DATE OF DEATH Month Day Year <b>Sept 14 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>St Francois County Mo, USA</b>
13a. FATHER'S NAME <b>James A Buchanan</b>		13b. MOTHER'S MAIDEN NAME <b>Louiza Patterson</b>	14. NAME OF HUSBAND OR WIFE <b>Ida Eaves Buchanan</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Shelton Buchanan, RFD #2, Farmington, Mo.</b>
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>Medullary paralysis</b> DUE TO (b) <b>Cerebral anoxia</b> DUE TO (c) <b>Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3-5 min</b> <b>10-15 hr</b> <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			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 s.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 <b>June 12, 1962</b> to <b>Sept 14, 1962</b> and last saw <b>him</b> alive on <b>Sept 14, 1962</b> . Death occurred at <b>8:00</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>James A. Armentrout DO</b> (Degree or title)		22b. ADDRESS <b>506 north St.</b>	22c. DATE SIGNED <b>9-15-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/16/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Three Rivers</b>	23d. LOCATION (City, town, or county) (State) <b>Near Farmington MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>C.H. COZEAN FARMINGTON MO.</b>		25. DATE RECD. BY LOCAL REG. <b>Sept. 15, 1962</b>	26. REGISTRAR'S SIGNATURE <b>Cather Rudloff</b>

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 *H Cozear*

Licensed Embalmer No. 4084

P. O. Address *Springer, 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.