

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

11803

**1. PLACE OF DEATH**

County Buchanan Registration District No. 85  
 Township Ways North Primary Registration District No. 1001  
 City St Joseph (No. Ways Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. 515

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Barba Buffington

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-2-1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
49 7 23

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Missouri  
 (STATE OR COUNTRY)

**PARENTS**  
 10. NAME OF FATHER Richard Buffington  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Illinois  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Jennie Davidson  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill  
 (STATE OR COUNTRY)

14. INFORMANT Mrs Barba Buffington  
 (Address) St Joseph Mo B R

15. FILED APR 25 1930  
John G. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 25 1930

17. I HEREBY CERTIFY, That I attended deceased from April 17 1930 to April 25 1930  
 that I last saw him alive on April 24 1930, and that death occurred, on the date stated above, at 9 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cancer of stomach  
 (duration) yrs. mos. ds. \_\_\_\_\_

CONTRIBUTORY (SECONDARY) Septic Ulcers  
 (duration) yrs. mos. ds. \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED 440  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) H. S. Goryunov M. D.  
4/25 1930 (Address) St Joseph Mo  
 \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Stonbury Mo DATE OF BURIAL 4/27 1930

20. UNDERTAKER Labou & Phillips ADDRESS Stonbury Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 11 5-9  
 22 1930

WRITE PLAINLY; WITH WRITING INSTRUMENTS IS A PERMANENT RECORD

