DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

791

State File No. 31305

REC'D OCT 14 1939

Registration District No. 1003

Primary Registration District No.

Registrar's No. 8368

1. PLACE OF DEATH:

(a) County St. Louis. 1

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution February 20, 1936 (Specify whether
In this community 25yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County ~~St. Louis~~ 1

(c) City or town St. Louis, Mo. 13
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? American years.

3. (a) PRINT FULL NAME John Buford. 163

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race Colored

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lena Buford

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased x (Month) x (Day) 1878 (Year)

8. AGE: Years 61 abt. Months x Days x If less than one day hr. min.

9. Birthplace Mississippi. (City, town, or county) (State or foreign country)

10. Usual occupation No Occupation 1

11. Industry or business x

FATHER
12. Name Harry Buford 1
13. Birthplace Mississippi. 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. Molony
(b) Address 5800 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/1939 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Avenue

19. (a) SEP 29 1939 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 25, year 1939 hour 5:55 minute a. M.

21. I hereby certify that I attended the deceased from February 20, 1936 to September 25, 1939 that I last saw him alive on September 25, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to Old Left Cerebral Hemorrhage

Due to Arteriosclerosis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. J. Brien M. D. (M. D. or other)
Address 5600 Arsenal Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39
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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 James A. Johnson, Registered Apprentice No. _____, working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

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 this body is not embalmed, above space should be left blank.