

FILED APR 6 1944

Registration District No. **227**

Primary Registration District No. **4339**

Registrar's No. **16**

9  
2  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **MONROE**

(b) City or town **PARIS**

(c) Name of hospital or institution:  
**SO. WASHINGTON ST. 1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **52 YRS** (Specify whether years, months or days)

In this community **52 YRS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **MONROE**

(c) City or town **PARIS**  
(If outside city or town limits, write "RURAL")

(d) Street No. **SO. WASHINGTON ST.**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country **✓**

3. (a) PRINT FULL NAME **LAURA VIRGINIA BUFORD**

3. (b) If veteran, name war **✓**

3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAR.** day **9**  
year **1944** hour **3** minute **05 A.** M.

21. I hereby certify that I attended the deceased from **6** to **11:44** on **MAR 9** 19**44**  
that I last saw **alive** on **MAR 9** 19**44**  
and that death occurred on the date and hour stated above.

4. Sex **FEMALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **ADDISON D. BUFORD**

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

7. Birth date of deceased **DEC. 14, 1860**  
(Month) (Day) (Year)

Immediate cause of death **Coronary Thrombosis** Duration **379**

Due to **arterio sclerosis** **21A**

Due to **✓**

Other conditions (Include pregnancy within 3 months of death)

8. AGE: Years **80** Months **2** Days **23** If less than one day hr. min.

9. Birthplace **MONROE Co., Mo. D**  
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

Major findings: **94a**

Of operations

Of autopsy

PHYSICIAN **—**  
Underline the cause to which death should be charged statistically.

11. Industry or business

MOTHER FATHER { 12. Name **DAVID M. CRAIG**

13. Birthplace **VA. 1**  
(City, town, or county) (State or foreign country)

14. Maiden name **MARY F. GIBSON**

15. Birthplace **MONROE Co., Mo. D**  
(City, town, or county) (State or foreign country)

16. (a) Informant **James D. Buford**

(b) Address **MEXICO, MO**

17. (a) **BURIAL** (b) Date thereof **MAR. 12, 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ORCH GROVE**

18. (a) Signature of funeral director **Speed Blafey**

(b) Address **PARIS, MO.**

19. (a) **3-9-44** (b) **Marym Carter**  
(Date received local registrar) (Registrar's signature)

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?

While at work (Specify type of place) (e) Means of injury

23. Signature **Geo M. [Signature]** (M. D. or D. O.)  
Address **PARIS, MO** Date signed **3-9-44**

RECEIVED

District Health Officer No. 10

District File Number 4-44-683

Date Filed APR 4 1944

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..

*A. Blakely*

Licensed Embalmer No. 2616

P. O. Address. PARIS, 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 this body is not embalmed, fact should be so stated above.