

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **27560**  
Registrar's No. **6961**Registration District No. **318**Primary Registration District No. **1003**

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

## 1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days  
(Specify whether  
In this community 40 yrs  
years, months or days)

3. (a) PRINT FULL NAME Norman Buford3. (b) If veteran,  
name war

3. (c) Social Security No.

4. Sex MALE 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if  
alive -- years  
7. Birth date of deceased August 23 1902  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
45 11 14 hr. min.

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

10. Usual occupation Nil11. Industry or business --

MOTHER FATHER { 12. Name Ishman Buford  
13. Birthplace Unk Georgia  
(City, town, or county) (State or foreign country)  
14. Maiden name Marly Jones  
15. Birthplace Unk Georgia  
(City, town, or county) (State or foreign country)

16. (a) Informant Henry Buford  
(b) Address 4404 Cote Brillant  
17. (a) Burial (b) Date thereof 8-10-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Boyd Bros. Funeral  
(b) Address 3704 Finney Ave  
19. (a) AUG 9 - 1948 (b) J. F. Bredbeck  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County nod  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3630 Cook  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6  
year 1948 hour 2 minute 40 A.M.

21. I hereby certify that I attended the deceased from  
August 4, 1948, to August 6, 1948;  
that I last saw him alive on August 6, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Lobar Pneumonia (Right)

Duration

Unk

Due to

Due to

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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? (c) Means of injury  
23. Signature Of Daniels (M. D. ---)  
Address 2601 N Whittier Date signed 8-6-48

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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.....

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

Signed Edward A Flynn

Licensed Embalmer No. 4444

P. O. Address 4548 20th

**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.**

Lucius 7664