

OCT 14 1939  
Registration District No. **291**

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: **1003**  
(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: City Hospital #1  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME Phillip Buford  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex Male  
5. Color or race Col  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife None  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 9 1 1891  
(Month) (Day) (Year)

8. AGE: Years 68 Months - Days 3  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Unknown ? ?  
13. Birthplace Unknown ? ?  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown ?  
15. Birthplace Unknown ?  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Scott Whitney  
(b) Address 2903 Franklin Ave

17. (a) Burial (b) Date thereof 9-9-39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Father's Burial Cave

18. (a) Signature of funeral director Edis Funeral Home  
(b) Address 2820 Stegand

19. (a) SEP 8 1939 (b) J. F. Bredeck  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 1  
(c) City or town St. Louis **[21]**  
(d) Street No. 2903 Franklin Ave  
(e) If foreign born, how long in U. S. A. No Physician in Attendance years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 4th  
year 1939 hour 5:40 minute A. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia  
Arterio Sclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy, within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Type of means of injury)  
23. Signature Alfred Perry (M. D. or other) \_\_\_\_\_  
Address Deputy Coroner Date signed 9-6-39

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.

**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 L. Boylston  
....., Registered Apprentice No. Imply  
working under my personal supervision.

Signed..... Lomnie Boylston  
Licensed Embalmer No. 2946  
P. O. Address St. Louis, 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, above space should be left blank.**