

Registration District No. **317**

Primary Registration District No. **3063**

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 16 days
(Specify whether years, months or days)
 In this community 21 YEARS

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Pine Lawn
(If outside city or town limits, write "RURAL")
 (d) Street No. 4719 Willow Wood
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mamie Buford
 3. (b) If veteran, name war --
 3. (c) Social Security No. --

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Robert Buford
 6. (c) Age of husband or wife if alive 61 years
 7. Birth date of deceased 10-27-1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>5</u>	<u>15</u>	hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Fritz Jennings
 13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Stuebach
 15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Buford
 (b) Address 4719 Willow Wood

17. (a) BURIAL (b) Date thereof 4-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW ST. MARCUS CEM

18. (a) Signature of funeral director L. B. Tamm

(b) Address 6107 1/2 Natural Bridge

19. (a) **APR 15 1944** (b) E. D. McLaughlin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4-11-44 day
 year _____ hour 8:10 minute A. M.

21. I hereby certify that I attended the deceased from 3-26-44 19____ to 4-11-44 19____
 that I last saw her alive on 4-11-44 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Gastrointestinal Malignancy
 Duration ?

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations 46 m
 Of autopsy _____

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 Becki Manning M.D.
 Address St. Louis County Hospital Date signed 4/11/44

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

96
2
3

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 *Henry M. Brammer*

Licensed Embalmer No. *4200*

P.O. Address.....

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.