

S. No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 22 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 230

1. PLACE OF DEATH a. COUNTY <u>Robert Koch Hospital</u> <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koch, Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>393 days</u>		<u>2069</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>1336 Walton</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lena</u> b. (Middle) _____ c. (Last) <u>Buford</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-26-52</u>	
5. SEX <u>3</u> <u>Fem</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-19-81</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>4</u> Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (One kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Mississippi, Oxford</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>Nelson Miles</u>	

13b. MOTHER'S MAIDEN NAME <u>Anna Mitchell</u>		14. NAME OF HUSBAND OR WIFE <u>John Buford (Deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Record at Robert Koch Hospital</u> ADDRESS _____			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis, F.A.</u>		DUPLICATE OF (b) _____		<u>3 1/2 yrs?</u>	
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUPLICATE OF (c) _____		_____	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		<u>Diabetes Mellitus</u>		<u>?</u>	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from 12-29-50 to 1-26-52, 1952, that I last saw the deceased alive on 1-26-52, 1952, and that death occurred at 8:15 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>H. G. Russell</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Robert Koch Hospital</u>		23c. DATE SIGNED <u>1-27-52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/1/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>1-28-52</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donike MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Gates</u>		ADDRESS <u>GATES FUNERAL HOME 4107 Finney Ave.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

1500

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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....



Signed.....

Student Embalmer

Licensed Embalmer No. 4259

P. O. Address 4107-7

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.