

FILED DEC 18 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42783**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **10640**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). --- a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (In this place) <b>5 wks.</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp.</b>			
e. STREET ADDRESS (If rural, give location) <b>2067 4719 Cote Brillante</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Mattie</b> b. (Middle) _____ c. (Last) <b>Buford</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>11 19 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>Unknown 1887</b>
9. AGE (In years last birthday) <b>Abt. 69</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (City and State or Foreign Country) / <b>Tenn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			

13a. FATHER'S NAME <b>Porter Stovall</b>	13b. MOTHER'S MAIDEN NAME <b>Little Haynes</b>	14. NAME OF HUSBAND OR WIFE <b>Lowell Buford</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No --</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Donnie Lee Brooks 4719 Cote Brill</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Adenocarcinoma, metastatic to lungs</b> <b>Primary unknown</b> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>dehydration - decubitus</b>		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>165x</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 **10-10-56** to **11-19-56**, 19\_\_\_\_, that I last saw the deceased alive on **11-19-56**, 19\_\_\_\_, and that death occurred at **3:10 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>John Niederwieser, M.D.</b>	23b. ADDRESS <b>5800 Arsenal St.</b>	23c. DATE SIGNED <b>11-20-56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11/23/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>NOV 21 1956</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Charles J. Gates 4107 Finney Ave.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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..

Student.....  
Signature of Student Embalmer

Signed *Arthur L. Heilliard*

Licensed Embalmer No. *422*

P. O. Address *4107 Jm*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.