

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

■63-041258

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10729**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 7 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA. Homer Phillips Hos.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3909 Maffitt Ave.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leota Middle Bufford Last						4. DATE OF DEATH Month 10 Day 27 Year 63					
5. SEX Female		6. COLOR OR RACE Col.		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH II/24/13		9. AGE (last birthday) 49		IF UNDER 1 YEAR Months 11 Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Operator				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA.			
13a. FATHER'S NAME Artice Bruce				13b. MOTHER'S MAIDEN NAME Lottie Mc Reynolds				14. NAME OF HUSBAND OR WIFE Fred E. Bufford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Fred E. Bufford 3907 Maffitt Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis										INTERVAL BETWEEN ONSET AND DEATH Terminal	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis										Unknown	
DUE TO (c) 4201											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from 10-19-63 to 10-27-63 and last saw her alive on 10-24-63 Death occurred at 9:35 A m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE M. D. (Degree or title)						22b. ADDRESS 2715 Union St. Louis			22c. DATE SIGNED 10-28-63 (State)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/31/63		23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)					
24. FUNERAL DIRECTOR ADDRESS Wright's Funeral Home 3100 Easton Ave.				25. DATE RECD. BY LOCAL REG. OCT 29 1963		26. REGISTRAR'S SIGNATURE Road Smith, M.D.					

VS 300 Rev. 4/59	DATE AMENDED	
1	1	
2	2	21/19
3	3	
4	4	3
5	5	1
6	6	
7	7	0
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9	9	
10	10	
11	11	
12	12	92-0
13	13	
91	14	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 C. Haselkirk

Licensed Embalmer No. 4221

P. O. Address 3150 Easton Ave

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.