MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

11622

1. PLACE OF DEATH
County Jackson — Registration District No. 399
Township Raw — Primary Registration District No. 1002
City Kansas City (No. K.C. General Hosp. St. ..... Ward)

File No. 1410
Registered No.

2. FULL NAME Ford Sadie
(a) Residence. No. Catherine Hale Home St. ..... Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 28 1863

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
63	6	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

PARENTS
10. NAME OF FATHER John Ford
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Mary Cofield
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Indiana

14. INFORMANT Record Clerk
(Address) K.C. General Hosp.

15. FILED 4/4, 1927 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-2 1927

17. I HEREBY CERTIFY, That I attended deceased from 2-20, 1927 to 4-2, 1927 that I last saw her alive on 4-2, 1927, and that death occurred, on the date stated above, at 6:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Starvation following Neurosis of blindness

878 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 84 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) George P. Lee, M.D.
4-2, 1927 (Address) Asst Supt K.C. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Moriah — DATE OF BURIAL: 4-4 1927

20. UNDERTAKER: Mrs C. L. Forster — ADDRESS: K.C. Mo.

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.