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

Do not use this space.

15094

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 1932
Township Kaw — Primary Registration District No. 1002 — Registered No.
City Kansas City (No. Trinity Luthern Hosp. St. Ward)

2. FULL NAME Robert Lee Ford
(a) Residence. No. 4943 State Line Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
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) May 12-1927

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, 8 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant 160
(b) General nature of industry, business, or establishment in which employed (or employer): 160
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

PARENTS
10. NAME OF FATHER Wm V. Ford
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kans.
12. MAIDEN NAME OF MOTHER Wilma Padgett
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT Tr. Wm V. Ford
(Address) 4943 State Line

15. FILED May 13 1927 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 1927

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1927, to , 19 , that I last saw him alive on May 12, 1927, and that death occurred, on the date stated above, at 1:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage of brain
161B
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hard labor and rapid (duration) yrs. mos. 1 1/2 hour

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) Siol Mooker, M.D.
5/13, 1927 (Address) 605 Bryant Bldg

*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: 5/13/27

20. UNDERTAKER: The Freeman Mortuary — ADDRESS: 3146 Main

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.