

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

Do not use this space.

30352

1. PLACE OF DEATH

County Boone
Towaship Deo Monroe
City Ches P Ford (No. 527)

Registration District No. 193
Primary Registration District No. H116

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Ches P Ford

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

Mr May Ford

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 3 1951

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 | 1 | 20 | 137 135c

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ret Banker
(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) Clark Co Mo

10. NAME OF FATHER

Henry H Ford

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Pa

12. MAIDEN NAME OF MOTHER

Hannah Holt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Pa

14. INFORMANT

Mrs Ches P Ford
(Address) Wayland Mo

15. FILED 8/25/29 H. Kieck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep 23 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1929, to Sept 23 1929, that I last saw ~~him~~ her alive on Sept 23 1929, and that death occurred, on the date stated above, at 8 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

137
135c
naemia
137D (duration) yrs. mos. 7 ds. 8

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. M. Mergie M. D.
, 19 (Address) Wayland Mo

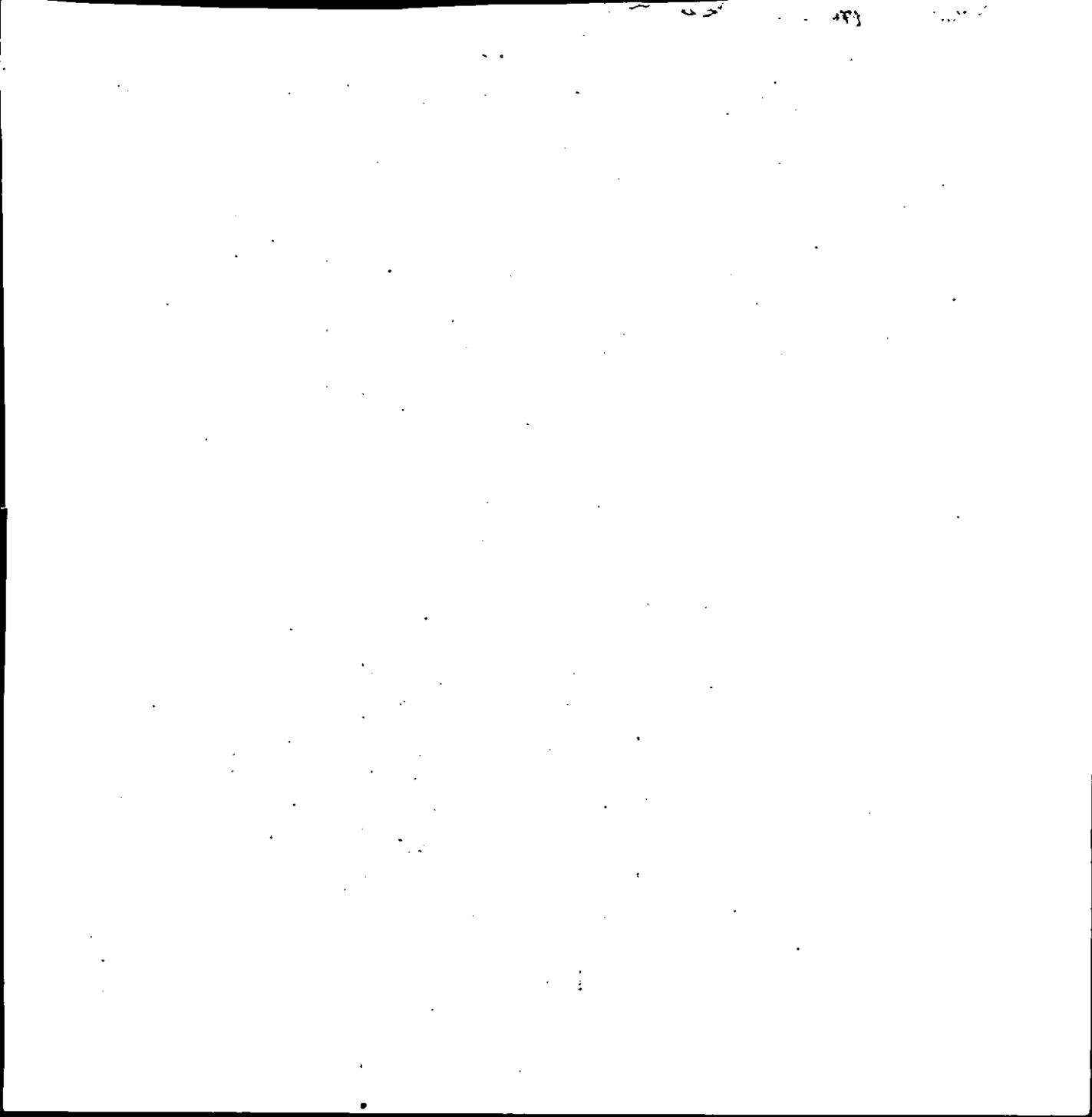
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Wolf Cemetery 9-25 1929

20. UNDERTAKER ADDRESS

H. F. Kieck Wayland



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Clark
Township Desmonde
City Chas. P. Fore (No. _____) St. _____ Ward _____

Registration District No. 193
Primary Registration District No. 3-2-70

File No. _____
Registered No. _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23 1929

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

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Tubercia
and the symptoms
of the disease
(duration) _____ yrs. mos. da.

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

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. da.

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

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

10. NAME OF FATHER _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

(Signed) _____, M. D.

, 19 _____ (Address)

*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.

INFORMANT _____ (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

19

FILED 9-26 1929 H. F. Archer REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

Exact statement of OCCUPATION is very important. FILE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

155

RECEIVED

APR 1952

12

DEPARTMENT OF THE ARMY, WASHINGTON, D. C.

OFFICE OF THE ADJUTANT GENERAL

ATTENTION: PERSONNEL SECTION

DATE: APR 19 1952

TO: THE ADJUTANT GENERAL

FROM: THE ADJUTANT GENERAL

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

30352

ADJUTANT GENERAL

WASHINGTON, D. C.

OFFICE OF THE ADJUTANT GENERAL

ATTENTION: PERSONNEL SECTION

DATE: APR 19 1952

TO: THE ADJUTANT GENERAL

FROM: THE ADJUTANT GENERAL

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]