

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

Do not use this space.

8970

1. PLACE OF DEATH

County Jackson Registration District No. 399

Township St. Louis Primary Registration District No. 1007

City Crystal (No. 1007)

File No. _____

Registered No. 1350

St. _____ Ward _____

2. FULL NAME

Cornelius Ford

(a) Residence. No. 1007 Crystal St. 12 Ward.

(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 M 4. COLOR OR RACE col 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 22 - 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
6 3

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) MO

10. NAME OF FATHER Daniel Ford

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

12. MAIDEN NAME OF MOTHER Cloria Finney

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

14. INFORMANT Daniel Ford
(Address) 1007 Crystal

15. FILED 3/27, 1930 M. M. Crowe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/25 1930

17. I HEREBY CERTIFY, That I attended deceased from 3 - 20 1930 to 3 - 20 1930 that I last saw him alive on 3 - 20 1930 and that death occurred, on the date stated above, at 6:30 AM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute General Peritonitis
119B
129 (duration) yrs. - mos. 4 1/2 ds.

CONTRIBUTORY (SECONDARY) Acute Ulcerative Colitis (duration) yrs. - mos. 11 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) [Signature], M. D.

3/26 1930 (Address) 320 P 2

*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

Highland

3/27 1930

20. UNDERTAKER

ADDRESS

Miller Bros 1729 Lydia

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

