

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

K. 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.

Oct 31 1930

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

Do not use this space.

130732  
Gullard

1. PLACE OF DEATH  
County Pettis Registration District No. 668  
Township \_\_\_\_\_ Primary Registration District No. 3032  
City Sedalia (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Catherine Elizabeth Ford  
(a) Residence No. 25 Dundee St 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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Nancy Ford</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct 3 1872</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>57</u>	<u>11</u>	<u>16</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Housewife</u> (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) <u>mo</u>				
PARENTS	10. NAME OF FATHER <u>John Callies</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>ky</u>			
	12. MAIDEN NAME OF MOTHER <u>Eliz. Neitzel</u>			
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>mo</u>				
14. INFORMANT <u>Nancy Ford</u> (Address) <u>Sedalia mo</u>				
15. FILED <u>9-30</u> , 19 <u>30</u> <u>J. L. Love</u> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (MONTH, DAY AND YEAR)	<u>Sept 19 1930</u>
17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 27</u> , 19 <u>30</u> , to <u>Sept 19</u> , 19 <u>30</u> that I last saw her alive on <u>Sept 19</u> , 19 <u>30</u> , and that death occurred, on the date stated above, at <u>9-10 p.m.</u>	
THE CAUSE OF DEATH* WAS AS FOLLOWS: <u>Pulmonary Phthisis</u> <u>73A</u> <u>117</u>	
(duration) <u>2</u> yrs. .... mos. .... ds.	
CONTRIBUTORY (SECONDARY) <u>Asthma</u> (duration) <u>3</u> yrs. .... mos. .... ds.	
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH..... DID AN OPERATION PRECEDE DEATH? <u>no</u> DATE OF _____ WAS THERE AN AUTOPSY? <u>no</u> WHAT TEST CONFIRMED DIAGNOSIS? <u>Symptomatology</u> (Signed) <u>A. K. Gullard</u> M. D. . 19 (Address) <u>3905 Ohio Sedalia Mo</u>	
*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 <u>Crown Hill</u>	DATE OF BURIAL <u>9/21 1930</u>
20. UNDERTAKER <u>Gillespie</u>	ADDRESS <u>Sedalia</u>

