

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

Do not use this space.

6627

1. PLACE OF DEATH

87 County Pike
 Township Prairieville
 City _____ (No. _____) St. _____ Ward _____

Registration District No. 687
 Primary Registration District No. 3-915

File No. _____
 Registered No. _____

2. FULL NAME

Wm. H. Ford

(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. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 19-1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 4 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer 1
 (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) Montgomery Co. Mo

PARENTS

10. NAME OF FATHER James M. Ford

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

12. MAIDEN NAME OF MOTHER Mary Ferguson

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

14. INFORMANT Ray Hawkins
 (Address) Esolia Mo

15. FILED 2/14, 1931 B. M. Gooch
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 14th 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb 7th, 1931, to Feb 14th, 1931 that I last saw him alive on Feb 14th, 1931, and that death occurred, on the date stated above, at 2:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
100%

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

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? General symptoms

(Signed) L. P. Huey, M. D.

, 19 _____ (Address) Esolia 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

Clarksville - Mo Feb 15-1931

20. UNDERTAKER ADDRESS

Gooch-Bushman Esolia 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.

U.S. AG
IN CHARGE

M. B. - BAKER
CHIEF OF POLICE

?

**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 Oake Registration District No. 687
 Township Pleasantville Primary Registration District No. 5-916
 City (No. _____) St. _____ Ward _____

File No. _____

Registered No. _____

2. FULL NAME Wm D. 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 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19__

19. UNDERTAKER (ADDRESS)

20. FILED Feb-24, 1931 A. M. Gouch Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 14, 1931

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19__

I last saw h. _____ alive on _____, 19__ Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia Date of onset _____

Lobar Pneumonia

Other contributory causes of importance:

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Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) _____, M. D.

(Address) _____

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-4627