

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

Do not use this space.

8621

1. PLACE OF DEATH
 County Wright Registration District No. 901
 Township West Salem Primary Registration District No. 6210
 City (No.) St. Ward

2. FULL NAME Katherine 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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Samuel Ford
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 22, 1858
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 2 6
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at home 23 1/2
 (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) Franklin Co. Mo.
10. NAME OF FATHER Edward Parker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Franklin Co. Mo.
12. MAIDEN NAME OF MOTHER Mr. Brown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mr. Brown

14. INFORMANT B. H. Hines
 (Address) Northview Mo.
15. FILED Mar 15 1931 Nellie Atkins
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 28 1931
17. I HEREBY CERTIFY, That I attended deceased from Jan. 30 1931 to Jan 30 1931
 that I last saw her alive on Jan. 30 1931, and that death occurred, on the date stated above, at 7-15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterial Sclerosis
99 (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? Cloned
 (Signed) H. N. Focht M. D.
317, 1931 (Address) Strofford 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 Int. Clinic **DATE OF BURIAL** 3/1 1931
20. UNDERTAKER J. P. Mahan **ADDRESS** Marshall

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.

MAR 27 1931

