

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

Do not use this space.

**31205**

**1. PLACE OF DEATH**

County Stone  
Township Washington  
City Salena (No.     )

Registration District No. 843  
Primary Registration District No. 6106

File No.       
Registered No.       
St.      Ward     

**2. FULL NAME**

(a) Residence. No. Salena Mo St.,      Ward.       
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 3 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 (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-25-1865

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>77</u>	<u>    </u>	<u>3</u>	<u>14</u>	<u>    </u>

**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) Parkville  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Martin Ford

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

12. MAIDEN NAME OF MOTHER Lucinda Clayton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)       
(STATE OR COUNTRY) Clay Co. Missouri

14. INFORMATION (Address) Mr. Pet Cole  
Salena Mo

15. FILED 9/10 19 32 Nellie Ironsley  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 8 19 32  
17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 19 32, to Sept 8, 19 32  
that I last saw him alive on Sept 7 30 a 19 32, and that death occurred, on the date stated above, at      in.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pneumonia  
191A  
191B  
CONTRIBUTORY Fractured Ribs  
(SECONDARY) (duration)      yrs.      mos.      ds.  
(duration)      yrs.      mos.      ds.

18. WHERE WAS DISEASE CONTRACTED      (1)  
IF NOT AT PLACE OF DEATH, yes

C DID AN OPERATION PRECEDE DEATH? no DATE OF     

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Parkville Mo.  
DATE OF BURIAL Sept 8 19 32

20. UNDERTAKER T. B. Chaffin  
ADDRESS Clark 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.

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.

SEP 30 1932

etate blin  
Jawrogr

TO

**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 St. Louis Registration District No. 843  
Township Wershington Primary Registration District No. 6106  
City St. Louis (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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.

OCCUPATION 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) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

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

MOTHER 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 9/10 1932 Nellie H. Bromley Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 8, 1932

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:

Measles Date of onset \_\_\_\_\_

fell while feeding chickens, on ground

Other contributory causes of importance: fractured hips

Name of operation 1860 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 \_\_\_\_\_

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) \_\_\_\_\_

SUPPLEMENTARY

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PARTS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BELOW.

S-31205