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.

OCT 17 1935

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

Do not use this space.

85 4
1001 1

28766

File No.
Registered No. 962

1. PLACE OF DEATH
County Buchanan
Registration District No.
Township Washington
Primary Registration District No.
City St Joseph (No. State Hospital #2 St. Ward)

2. FULL NAME Oliver L. Ford
(a) Residence, No. State Hospital #2 St., Ward. Grundy Co. Mo
(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: Male
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) May 8-1859

7. AGE: YEARS 76 MONTHS 4 DAYS 8 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Cabinet Maker
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) Livingston Co Mo

FATHER
13. NAME Milton L. Ford
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Franklin Co Ind.

MOTHER
15. MAIDEN NAME Mary Jane Humphrey
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fulton Mo

17. INFORMANT (ADDRESS) Records State Hosp St Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE State Hospital cemetery DATE Sept. 18, 1935

19. UNDERTAKER E. R. Sidenfaden
(ADDRESS) 602 South 10th Street

20. FILED 9-8, 1935 John R. Bender
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 16, 1935

22. I HEREBY CERTIFY, That I attended deceased from State Hosp #2 July 22, 1935, to Sept 16, 1935
I last saw him alive on Sept 15, 1935. Death is said to have occurred on the date stated above, at 7:00 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
~~Bronchopneumonia~~	
Acute Cholecystitis	Sept 12-35
and Cholelithiasis	

Other contributory causes of importance:
Chronic Myocarditis

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? No

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? No
If so, specify
(Signed) Dr Clifton Smith M. D.
(Address) State Hosp #2 St Joseph Mo