

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

791  
1003

16865  
Do not use this space.

1. PLACE OF DEATH <sup>REC'D JUN 12 1939</sup>  
 (a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No..... Registered No. **4399**  
 (c) City **St. Louis** (d) Street No. **Bethesda Hospital** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Lillian Ann Ford**  
**3819a Blaine Ave.**  
 (a) Residence, No. **3819a Blaine Ave.** St. **17** (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** 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 **Luther Ford**  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Unk. Unk. 1865**  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**73 Unk. Unk.**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**  
 9. Industry or business in which work was done, as 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) **Madisonville**  
 (STATE OR COUNTRY) **Ky.**

FATHER 13. NAME **James Green Foley**

14. BIRTHPLACE (CITY OR TOWN) **Madisonville**  
 (STATE OR COUNTRY) **Ky.**

MOTHER 15. MAIDEN NAME **Mary Poag**

16. BIRTHPLACE (CITY OR TOWN) **Greenville**  
 (STATE OR COUNTRY) **Ky.**

17. INFORMANT **Miss Lucille Papin**  
 (ADDRESS) **3819a Blaine Ave.**

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE **Calvary** DATE **May 13, 1939**

19. FUNERAL DIRECTOR (NAME) **Arthur J. Donnelly**  
 (ADDRESS) **3840 Lindell Blvd.**

20. FILED **MAY 12 1939**  
**J. J. Budwick** Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 10, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **May 2, 1939**, to **May 10, 1939**  
 I last saw **her** alive on **May 10, 1939**. Death is said to have occurred on the date stated above, at **3:35 pm.**  
 The principal cause of death and related causes of importance were as follows:

**Cerebral Hemorrhage**  
**Hypertension**  
**Diabetes mellitus**  
**arteriosclerosis**

Date of onset **5-2-39**

Other contributory causes of importance:  
**Hypertension**  
**Diabetes mellitus**  
**arteriosclerosis**

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? **No.**  
 If so, specify.....  
 (Signed) **John B. Lynn**, M.D.  
 (Address) **1715 E. 135th St**  
**St. Louis, Mo**

THIS IS A PERMANENT RECORD

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.

