

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **23586**  
Registrar's No. **5859**

REG'D AUG 11 1939

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 7151 Wellington Court  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)3. (a) PRINT FULL NAME 630 Anne Mae Ford

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Robert G Ford 6. (c) Age of husband or wife if alive 61 years7. Birth date of deceased Sent. 4, 1880  
(Month) (Day) (Year)8. AGE: Years 58 Months 9 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace Jerseyville Ill  
(City, town, or county) (State or foreign country)10. Usual occupation Housewife home

11. Industry or business \_\_\_\_\_

12. Name Abraham Richards13. Birthplace New Jersey  
(City, town, or county) (State or foreign country)14. Maiden name Carrie Conds  
(City, town, or county) (State or foreign country)15. Birthplace Ill  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Robert G Ford(b) Address 7151 Wellington Ct.17. (a) burial (b) Date thereof July 3, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Jerseyville, Ill18. (a) Signature of funeral director Duchmann Harold(b) Address 1905 Union Blvd19. (a) JUL 2 1939 (b) Jan Bedek  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis 3  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 7151 Wellington Court  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30  
year 1939 hour 7 minute 30 A. M.21. I hereby certify that I attended the deceased from June 30, 1939, to June 30, 1939;  
that I last saw her alive on June 30, 1939,  
and that death occurred on the date and hour stated above.Immediate cause of death cerebral hemorrhage Duration 18 hours

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions terminal cerebral  
(include pregnancy within 3 months of death) infarction

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline the cause to which death should be charged statistically

## 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. Brozard M.D. (M. D. or other) \_\_\_\_\_Address 3500 Cambridge Date signed \_\_\_\_\_

3500, Cambridge  
1-2

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Warren A. Carver

Licensed Embalmer No. 3534

P.O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**