

LET DEC 12 1940

Registration District No. 461 Primary Registration District No. 5625 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County. Lafayette
 (b) City or town. Lexington
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 2
 In this community. Most of her life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Miriam Catron 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 Widowed
 6. (b) Name of husband or wife. Walter Ford 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased. Sept. 11, 1858
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>1</u>	<u>23</u>	hr. _____ min.

9. Birthplace. Jackson Co., Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation. At Home

11. Industry or business _____
 { 12. Name Bronson Catron
 13. Birthplace Virginia
(City, town, or county) (State or foreign country)
 14. Maiden name Ann Suddath
 15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant. Miss Adolyne Ford
 (b) Address. Lexington, Mo.

17. (a) Burial (b) Date thereof. Nov. 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation. Lexington, Mo.

18. (a) Signature of funeral director. Winkler
 (b) Address. Lexington, Mo.

19. (a) Nov 7/1940 (b) Delia Bates
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Lafayette
 (c) City or town. Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 5 Miles east of Lexington
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4th
 year 1940 hour 5 minute 15 P.A.M.

21. I hereby certify that I attended the deceased from Oct, 1936, to Nov, 1940
 that I last saw her alive on Nov 3rd, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death. Pseudobulbar Paralysis
 Due to _____
 Due to _____
 Other conditions. grip
(Includes pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 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?
890
(Specify type of place) While at work? (e) Means of injury _____

23. Signature R. B. Watts (M.D. or other) _____
 Address Wellington Mo signed 11/4/40

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12-12-40

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 Geo. A. McKean
Licensed Embalmer No. 2983
P. O. Address Jerington Mo

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, fact should be so stated above.