

LET 9 1941, 25
District No. _____

Primary Registration District No. 3009

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 84 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Cape Girardeau
(c) City or town Cape Girardeau
(If outside city or town limits, write "RURAL")
(d) Street No. R 1500
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ELBERT FORD
3. (b) If veteran, no name war _____
3. (c) Social Security No. 1-4-41

4. Sex OM 5. Color or race W
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased NOV 16 1904
(Month) (Day) (Year)
8. AGE: Years 36 Months 9 Days 10
If less than one day _____ hr. _____ min.

9. Birthplace Missouri (City, town, or county) (State or foreign country) 0

10. Usual occupation Working in a store

11. Industry or business Working in a store

12. Name Milva Ford
13. Birthplace Illinois (City, town, or county) (State or foreign country)
14. Maiden name Eloise Fordson
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maggie Shaw
(b) Address Tullahoma MO
17. (a) Burial (b) Date thereof Aug 27-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Parma Cemetery

18. (a) Signature of funeral director T. E. Knight
(b) Address Parma
19. (a) 8-27-41 (b) J. M. Thompson
(Date received local registrar) (Registrar's signature)

See other side (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 26
year 41 hour 12 minute 25P M.
21. I hereby certify that I attended the deceased from 8:20 1941 to 8/26 1941
that I last saw him alive on 8/26 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Tumor of Brain
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

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 St. Francis (M. D. or other) MD
Address Cape Girardeau State MO Date signed 8/27/41

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

Mr. Elbert Ford had spent very little time in Parma Community where his people live during the past several years in fact his folks say he was gone two years past without communicating with them. His Father says he had been working on a drag line on a dam near Jefferson City Tenn. He was taken from Jefferson City Tenn to a hospital in Atlanta Ga and later returned to Tenn from where he came to his folks near Parma. Regarding Social Security no. he was carrying a card in name of Artie Alford Barnes but on his identification card he has his name with same number 428-07-5609

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

J. C. Knight

Licensed Embalmer No. *2109*

P. O. Address. *Parma Mo*

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

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37966

Registration District No. 125

Primary Registration District No. 3009

Registrar's No. 319

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Francis Hosp.
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elbert Ford

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 26 Year 194 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

removal of Brain

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

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 Ab Duerr (M. D. or other) _____

Address Cape Girardeau Date signed 10/14

SUPPLEMENTARY

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

Cape Girardeau

MOTHER FATHER

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27966

Registration District No. 125

Primary Registration District No. 3009

Registrar's No. 319

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: H. Schroeder Hosp.
(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 Elbert Ford

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Sm 5. Color or race W (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years _____ Months _____ Days _____ if less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-27-1941 (b) J. M. Thompson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I first saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY