

FILED OCT 2 1942

State File No. _____

Registration District No. 280

Primary Registration District No. 4421

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Parkville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 72 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME SAMUEL P. FORD

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Maud Emma Ford 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased 8-15-1870
(Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Physician

11. Industry or business _____

MOTHER FATHER
12. Name Joseph Ford
13. Birthplace Platte Co.
(City, town, or county) (State or foreign country)
14. Maiden name Marion Estes
15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Pauline Link
(b) Address Parkville, Mo.

17. (a) Burial (b) Date thereof Aug 28 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parkville

18. (a) Signature of funeral director Voland
(b) Address Parkville, Mo.

19. (a) Sept 1-1942 (b) Mrs. Clay Siffel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25
year 1942 hour 8:45 minute 45 P. M.

21. I hereby certify that I attended the deceased from Feb. 14 1938 to Aug 25 1942
that I last saw him alive on Aug 24 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 3 das.

Due to _____
Due to _____

Other conditions Chronic Myocarditis 3 yrs.
(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 L. A. Marty (M. D. or other) 0
Address 815 McFee St. Date signed 8/31/42

1209

(Licensed Embalmer's Statement on Reverse Side) Kansas City, Mo

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

83
000

5-17-39
X29484

*L. A. Marley
8/15-1942*

RECEIVED

District Health Officer No. Platto
District File Number 10-42-79
Date Filed 10-2-42

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31106
Registrar's No. 16

Registration District No. 280

Primary Registration District No. 4421

1. PLACE OF DEATH:

(a) County Platte
(b) City or town Parkville
(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 _____
(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 Samuel P. 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 m

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

7. Birth date of deceased: Aug 14 (Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days no 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1942 hour _____ minute _____ M.

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

Labar

Due to _____

Due to _____

Other conditions Chronic Myocarditis 3/19/40.
(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 _____

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

SUPPLEMENTARY

[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is scattered across the page and cannot be transcribed accurately.]