

No. 2  
10-4-41  
17-39  
X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **36690**

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **789**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **St Joseph Mo.**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **State Hospital # 2, 2**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **June 4/14/42**  
(Specify whether **Same**)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**

(c) City or town **Blue Springs**  
(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 **WM - Webber Ford**

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

4. Sex **Male** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Mrs Alice Ford** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Nov 11 - 1861**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>80</b>	<b>11</b>	<b>9</b>	hr. min.

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

10. Usual occupation **Carpenter**

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

MOTHER FATHER

12. Name **Edmond Ford**

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

14. Maiden name **Alicia H. Adair**

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

16. (a) Informant **State Hospital Reads**

(b) Address **R. St Joseph Mo.**

17. (a) \_\_\_\_\_ (b) Date thereof **11-12-42**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or \_\_\_\_\_ **Blue Springs Mo**

18. (a) Signature of funeral director **W. B. Bell & Son**

(b) Address **Blue Springs Mo**

19. (a) **11-12-42** (b) **Ray Henry**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **9th**  
year **1942** hour **12 M.** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **July 15th**  
**1942**, 19 \_\_\_\_\_, to **November 9th** 19 **42**  
that I last saw h. **E** alive on **November 5th** 19 **42**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive pneumonia** ✓ **3 da**  
**Scurvy**

Due to **Scurvy**

Due to **Cerebral arteries - Sclerosis**

Other condition **Psychotic**  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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

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 **Ed Dembar M.D.** (M. D. or other)

Address **St Joseph Mo** Date signed **11-10-42**

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

**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.....

*P. B. Webb*

Licensed Embalmer No.....

*2353*

P. O. Address.....

*Blue Spring*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com-  
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. 36690

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 789

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph, Mo.  
(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 years, months or days)

3. (a) PRINT FULL NAME Wm Weller 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 Nov 11 1880  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	11	13	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)

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 Nov Day 13 Year 1962 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I have seen him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Suppurative pneumonia Bronchitis Duration 3 days

Due to Senility

Due to Cerebral arterio sclerosis psychoneurotic

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 101

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. H. Dunham (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

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

11-10-62

S-36690