

STANDARD CERTIFICATE OF DEATH
FILED JAN 15 1943

State File No. 41909
Registrar's No. 2811

Registration District No. 101 Primary Registration District No. 101

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

96
302

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St Louis County Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 da (Specify whether
Life (Specify whether
years, months or days)

3. (a) PRINT FULL NAME John R Ford

3. (b) If veteran, name war ////////// 3. (c) Social Security No. 498-01-0842

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Sept 22 1912
(Month) (Day) (Year)

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

30 3 8 _____ hr. _____ min.

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

10. Usual occupation Chauffeur

11. Industry or business Trucking

MOTHER FATHER

12. Name Joseph H Ford

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

14. Maiden name Pearl Millison

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

16. (a) Informant Joseph H Ford

(b) Address 3239 Midway Overland Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Lebanon Cemetery

18. (a) Signature of funeral director Ortman Funeral Home

(b) Address 9222 Lockland Overland Mo

19. (a) JAN 2 - 1943 (Date received local registration) (b) C. L. McFarren M.D. (Registrar's signature) S.W.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis

(c) City or town Overland (If outside city or town limits, write "RURAL")

(d) Street No. 3304 Pasteur (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 30
year 1942 hour 3:15 minute A M.

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

Immediate cause of death Natural causes. Duration _____

Due to Pneumonia involving lower lobe of left lung; Congestion and edema of upper lobe of left lung; Interstitial emphysema of lower & middle lobe of right lung; Hydro-

Other conditions sema of lower & middle lobe of right lung; Hydro-
(Include pregnancy within 3 months of death)
Major findings: thorax.

Of operations _____
Of autopsy Yes.

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? _____

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

23. Signature Louis H B M (M. D. or other) _____
Address Kirkwood, Mo. Date signed 12/31/42

STATE OF
MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
HEALTH CERTIFICATE

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 Albert Ostmann
of the County of _____
Licensed Embalmer No. 3478

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.