

V. S. No. 2  
FORM-2-43  
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27311

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED AUG 21 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3434

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
St. Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Month  
50 Yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Benjamin F. FORD.

3. (b) If veteran, name war None

3. (c) Social Security No. 495-01-1989

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Josephine Ford

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased September 9th 1882  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
60	10	30	29 hr. min.

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

10. Usual occupation Baker

11. Industry or business Janoe Bakery.

MOTHER FATHER {

12. Name Thomas Ford

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Alta Ford Lynch

(b) Address 3242 Spruce Ave.

17. (a) Burial (b) Date thereof 8/10/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Melody-McGilley

(b) Address K. C. Mo.

19. (a) 8-9-43 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. 3242 Spruce Ave.  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8th  
year 1943 hour 5 minute A.M.

21. I hereby certify that I attended the deceased from July 25 1943 to Aug 8, 1943  
that I last saw him live on Aug 5, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of rectum Duration 1 year

Due to intestinal obstruction

Due to 462 2 weeks

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

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

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

Of autopsy: Carcinoma of rectum - Squamous.

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 M. C. Casebolt (M. D. or other)  
Address 400 Baltimore St. No. 8/9/43

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

*Handwritten scribbles*

**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.**