

U. S. No. 2
DOM-2-43
Rev. 5-17-39
X3389

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29381

State File No.

ED SEP 21 1943 318

Registration District No. 1003

Registrar's No. 7702 ✓

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
5007 Cates Ave
(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)

In this community 4 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
12

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
9/2

(d) Street No. 5007 Cates Ave
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME William E Ford

3. (b) If veteran, name war World

3. (c) Social Security No. None

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

6. (b) Name of husband or wife Frances E 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased June 23rd 1894
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>2</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation Lineman

11. Industry or business Telephone Co

12. Name Martin Ford

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

14. Maiden name Elizabeth Hayes

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

16. (a) Informant Mrs Frances Ford

(b) Address 5007 Cates Ave

17. (a) Burial (b) Date thereof 8/30/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Natl Cent

18. (a) Sign of the Director Harrison & Sheehan Und Co

(b) Address 4416 Washington Blvd

19. (a) AUG 27 1943 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26
year 1943 hour 11:25 Pm minute 25 P

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

Immediate cause of death Coronary Heart Disease
atherosclerotic Remodeling

Due to _____

Due to 9/4

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

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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 Thomas F Callahan (M.D. or other)
Address Deputy Coroner Date signed 8/27/43

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. Allen Blaine Jr

Licensed Embalmer No..... *4053*

P. O. Address..... *City*

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.