

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JUL 12 1944

2000

Registrar's No. 529

Registration District No. ....

Primary Registration District No. ....

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

229  
226

1. PLACE OF DEATH:

GREENE

(a) County.....  
(b) City or town.....  
(c) Name of hospital or institution.....  
(d) Length of stay: In hospital or institution.....  
In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(d) Street No.....  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Mrs. Inez Ethel Ford

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
58 1 22 hr. 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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day..... year..... hour..... minute.....

21. I hereby certify that I attended the deceased from..... to.....  
that I last saw her alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Due to.....  
Due to.....

Other conditions..... (Include pregnancy within 5 months of death)

Major findings:.....  
Of operation.....  
Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where and 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. D. or other)  
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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..... *Lee Harvey* .....

Licensed Embalmer No..... *5312* .....

P. O. Address..... *Maribeth Mrs* .....

**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.**

*X*