S. No. 2
—11-10-39
. 5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 12, 1945

Registration District No. 171

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5-637

State File No. 41437

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town ~~Wellington Mo.~~ RFD # 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Clay Twp
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette 54 0 0

(c) City or town Wellington Mo. RFD # 1
(If outside city or town limits, write "RURAL")

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

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JAMES - FORD

3. (b) If veteran, name war Mo

3. (c) Social Security No. 495-07-3564

4. Sex Male

5. Color or race Wht

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 9 (Month) 1883 (Day) (Year)

8. AGE: Years 61 Months 10 Days 13 If less than one day hr. min.

9. Birthplace Olatha Kansas 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Same

FATHER
12. Name John Ford
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Opal Pitz 1
(b) Address Lexington Mo 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-44 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery, Wellington Mo

18. (a) Signature of funeral director W. Ry Cullen
(b) Address Wellington Mo

19. (a) Dec-27-1944 (Date received local registrar) (b) Mrs. W. F. Baker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 22
year 1944 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec. 6, 1944, to Dec. 22, 1944
that I last saw him alive on Dec. 22, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Asthma	
Due to	
Due to 112	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 2

23. Signature D. K. Kirby (M. D. or other) DO
Address Wellington, Mo. Date signed 12-23-44

1157 (Licensed Embalmer's Statement on Reverse Side)

JAN 17 1945

RECEIVED
District Health Officer No. 8,
[illegible] File Number
Date Filed 1-10-45

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 W Roy Owen

Licensed Embalmer No. 4305

P. O. Address Wellington Mo

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, above space should be left blank.