S. No. 2
M—5-43
7. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

40095

FILED DEC 28 1945

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5133

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9yrs. 10 mo. 2 days (Specify whether
In this community unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 903 Independence Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William Ford

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years About 60 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant Medical Records Librarian
(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (Month) (Day) (Year)
(c) Place: burial or cremation Leed C

18. (a) Signature of funeral director Wm A Lohmeyer
(b) Address City Mortician

19. (a) 12-13-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29, year 1945 hour 11: minute 15 A.M.

21. I hereby certify that I attended the deceased from December 27, 1945 to October 29, 1945 that I last saw him alive on October 29, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Osteomyelitis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 154 b²	
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

23. Signature G C Siegner (M. D. or other)

Address General Hospital #2 Date signed 12/12/45

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(Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Wm A Lohmeyer

Licensed Embalmer No. 3089

P. O. Address Ft C 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, fact should be so stated above.