

UNITED STATES BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12642**
Registrar's No. **130**

FILED APR 24 1947

Registration District No. **47**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH:

(a) County **Cook County**
(b) City or town **Easton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 yr 11 mo 13 days**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **FORD, EARL**

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

4. Sex **M** 5. Color or Race **White** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **Feb 11 1914**
(Month) (Day) (Year)

8. AGE: Years **62** Months **0** Days **23** If less than one day hr. _____ min. **0**

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

10. Usual occupation **W. P. H.**

11. Industry or business _____

MOTHER FATHER

12. Name **M. J. ...**

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

14. Maiden name **DK**

15. Birthplace **DK** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Records**

(b) Address **State Hospital No. 1 Easton**

17. (a) **Removal** (b) Date thereof **4 5 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Columbia Mo**

18. (a) Signature of funeral director **G. O. Robert**

(b) Address **Columbia Mo**

19. (a) **4-5-1949** (b) **Josie M. ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene** **14**
(c) City or town **Springfield** **1**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **2**
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **April**
year **1947** hour **4:00** minute _____ M.

21. I hereby certify that I attended the deceased from **1 Dec 1947** to **4 April 1947**
that I last saw him alive on **April 3**, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis** Duration **3 days**
Due to _____
Due to _____

Other conditions **See history missing**
(Include pregnancy within 3 months of death)

Major findings: **Emphysema, etc.**

Of operations _____

Of autopsy **30/3**

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 **Wayne ...** (M. D. or other) **0**

Address **St. ...** Date _____

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 4-23-47

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.