

FILED JAN 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1141

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 11

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

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
c. LENGTH OF STAY (in this place) 50 days		d. STREET ADDRESS (If rural, give location) 5331 Highland	
d. FULL NAME OF HOSPITAL OR INSTITUTION LITTLE SISTERS OF THE POOR			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM		b. (Middle)	
c. (Last) FORDE		4. DATE OF DEATH (Month) (Day) (Year) JAN. 2, 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1864
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME MATTHEW FORDE		13b. MOTHER'S MAIDEN NAME ANNIE BERNIE	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Record	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS SISTER EMILIE, 5331 Highland Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			
MEDICAL CERTIFICATION:			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		years?	
DUE TO (b) Chronic Myocarditis		20 yrs	
DUE TO (c) Generalized Arterio-sclerosis			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1946 , to Jan 2, 1950 , that I last saw the deceased alive on Jan 2, 1950 , and that death occurred at 9:24 a.m., from the causes and on the date stated above.			
23a. SIGNATURE John F. Skinner (Degree or title)		23b. ADDRESS 1402 Bryant Bldg	
23c. DATE SIGNED 1/3/50			
24. BURIAL CREMATION REMOVAL (Specify) burial (1)	24b. DATE 1/4/49 50	24c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE REC'D BY LOCAL REG. 1-3-50	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 20 W. Linwood	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Forrest D. Coldman

Licensed Embalmer No. 3714

P. O. Address R. E. W.

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.