FILED JUN 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19385

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5268

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Faith Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo 2209
d. STREET ADDRESS (If rural, give location): 20 2541 E University St

3. NAME OF DECEASED (Type or Print)
a. (First): Jeanette
b. (Middle):
c. (Last): Ford

4. DATE OF DEATH (Month) (Day) (Year): 5 24 53

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 8-18-1889

9. AGE (In years last birthday): 63 — If under 1 year: Months / Days — If under 1 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St. Louis, Mo

12. CITIZEN OF WHAT COUNTRY?: D

13a. FATHER'S NAME: George Ruloff

13b. MOTHER'S MAIDEN NAME: Margaret Bennings

14. NAME OF HUSBAND OR WIFE: Richard J Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ——— (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: no

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mr Richard Ford 2541 E University St

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of Myocardium — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocardial Infarct — 3 days

DUE TO (c) Coronary Occlusion — 3 days.

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:

20. AUTOPSY? YES ☑ NO ☐

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) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: 4201

22. *I hereby certify that I attended the deceased from* 10-15, 1952, *to* 5-24, 1953, *that I last saw the deceased alive on* 5-24, 1953, *and that death occurred at* 9:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph B. Guccione MD

23b. ADDRESS: 2801 N. Taylor

23c. DATE SIGNED: 5/25/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 5-27-53

24c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

24d. LOCATION (City, town, or county) (State): St. Louis, Mo

DATE REC'D BY LOCAL REG.: MAY 26 1953

REGISTRAR'S SIGNATURE: J. Earl Smith M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Goodhart-Goodhart 2228 St. Louis, Av

G.O. (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 M

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed W W Wilkins

Licensed Embalmer No. 3575

P. O. Address St Louis M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.