

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **33503**

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>91899</b>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>East St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Infirmary</b>				e. STREET ADDRESS (If rural, give location) <b>1502 Gay Ave</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Frankie</b>		b. (Middle) <b>Lee</b>		c. (Last) <b>Ford</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		4. DATE OF DEATH (Month) (Day) (Year) <b>9-25-57</b>	
8. DATE OF BIRTH <b>9-25-57</b>		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months   Days		IF UNDER 15 Hrs. Hours   Min. <b>32</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Levi Ford</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ann Dukes</b>		14. NAME OF HUSBAND OR WIFE			
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.		17. INFORMANT'S SIGNATURE OR NAME <b>Mary Ford</b> ADDRESS <b>1502 Gay E. St. Louis, Mo.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pro lapsed Cord</b>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b)					
		DUE TO (c) <b>761.0</b>					
		II. OTHER SIGNIFICANT CONDITIONS <b>massive hemorrhage of liver, Tontorial tear &amp; cerebral hemorrhage.</b>					
		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 <input checked="" type="checkbox"/> NO <input 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) (Min)		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 <b>9-25, 1957</b> , to <b>9-25, 1957</b> , that I last saw the deceased alive on <b>9-25, 1957</b> , and that death occurred at <b>2:12 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Johnnie Jackson M.D.</b>				23b. ADDRESS <b>1502 Gay Ave E. St. Louis, Mo.</b>		23c. DATE SIGNED <b>9-25-57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>OCT 31 57</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		
DATE REC'D BY LOCAL REG. <b>OCT 2 57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland Allen</b> ADDRESS <b>404 Municipal</b>			

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

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**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.....  
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**