

JRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-010246

STATE FILE NUMBER

Registration District No. 65 Primary Registration District No. 4113 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>CHARITON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CHARITON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BRUNSWICK</u>	Length of stay in 1b <u>MOST OF HIS LIFE TIME</u>	c. CITY OR TOWN <u>BRUNSWICK</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>108 S. SCOTT ST.</u>		d. STREET ADDRESS (If outside, give location) <u>108 S. SCOTT ST.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>FORD</u> Last <u>FORD</u>	4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1960</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO FACTORY WORKER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOBILE INDUST</u>	11. BIRTHPLACE (City and state or country) <u>BRUNSWICK, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>CHARLES FORD</u>	13b. MOTHER'S MAIDEN NAME <u>LEASE WILLIAMS</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Pearl Clark, Kansas City, Missouri</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u>		<u>15 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension</u>	<u>20 yrs</u>
	DUE TO (c) <u>Arteriosclerosis</u>	<u>20 yrs</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u> </u> s.m. <u> </u> p.m. <u> </u>	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 3-20-60 to 3-20-60 and last saw her him alive on
Death occurred at 8 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>D. W. Stuart M.D.</u>	(Degree or title)	22b. ADDRESS <u>Brunswick</u>	22c. DATE SIGNED <u>3-23-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAR. 23, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>BRUNSWICK, MISSOURI</u>
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24. FUNERAL DIRECTOR <u>HEISEL F.H., BRUNSWICK, MISSOURI</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Mar 28 - 1960</u>	26. REGISTRAR'S SIGNATURE <u>Dovie Smith</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mr. D. D. Stewart M.D.

STATEMENT BY LICENSED EMBALMER

APR 5 196

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William R. Koc

Licensed Embalmer No. 4751

P. O. Address Brunswick

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.