

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

20300

1. PLACE OF DEATH

County..... *Polk*
Township..... *Polk*
City..... *Frankford* (No.) St. Ward)

Registration District No. *688*
Primary Registration District No. *4412*

File No.
Registered No. *10*

2. FULL NAME

Mary Magdalene Ford
(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *66* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* | 4. COLOR OR RACE *White* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Widow of EIGHTON FORD*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 12, 1849*

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.
81 | 5 | 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... *Housekeeper for self*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Polk Co Mo.*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *South Car.*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Mo.*

14.

INFORMANT..... *Josephine Ward*
(Address) *Frankford, Mo.*

15.

FILED *July 5, 1930* *Mattie Urso*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 22, 1930*

17. I HEREBY CERTIFY, That I attended deceased from *May 12* 19*26*, to *June 22* 19*30*, that I last saw him..... alive on..... 19*30*, and that death occurred, on the date stated above, at..... m. *8*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General of
46 B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

44 A (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *W. W. Jones* (Address) *Frankford Mo.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Frankford Mo *June 23 1930*

20. UNDERTAKER

ADDRESS

E. A. Lields *Frankford*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

82
+
24
3

