

AUG 20 1930

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

Do not use this space.

22162

1. PLACE OF DEATH

County Cape Girardeau  
Township 1st  
City near Jackson Mo. (No. ....)

Registration District No. 124  
Primary Registration District No. 5179

File No. ....  
Registered No. 45  
St. .... Ward)

2. FULL NAME

Ellie Arbella 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 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) married

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF Larrence Ford

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 14 1901

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
29 4 9

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. Housewife  
(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) Missouri

10. NAME OF FATHER L. L. Jones

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Ellie Robinson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Larrence Ford  
(Address) Jackson Mo R # 3

15. FILED 7-30-30 D. G. Leibert REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 28 19 30

17. I HEREBY CERTIFY, That I attended deceased from July 18, 19 30 to July 28, 19 30 that I last saw h. e. alive on July 18, 19 30 and that death occurred, on the date stated above, at 7:00 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Broncho Pneumonia  
141  
107h (duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Miss Carriage (duration) yrs. mos. 4 ds.

18. WHERE AND DISEASE CONTRACTED 1450 Oak Grove  
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Smear studies  
(Signed) D. G. Leibert, M. D.

7-30, 1930 (Address) Jackson 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 Russell Heights DATE OF BURIAL July 30 19 30

20. UNDERTAKER McCombs Funeral Home Jackson Mo ADDRESS

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

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