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.

REC'D MAY 10 1938

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

2 791 1003

12622
Do not use this space.
3226

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No..... Registered No.....

(c) City St Louis (d) Street No. 4449 Farlin Ave St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wm M. Ford 630

(a) Residence, No. 4449 Farlin Ave St. 10
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Vogt

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 8th 1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	64	7	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois 1 5

FATHER

13. NAME Michael Ford 5

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER

15. MAIDEN NAME Delia Manion

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Mrs Elizabeth Ford
(ADDRESS) 4449 Farlin Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE April 7th, 38

19. FUNERAL DIRECTOR Stroot - Carroll
(ADDRESS) 4600 Natural Bridge

20. FILED APR 5 1938 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 4 1938 19

22. I HEREBY CERTIFY, That I attended deceased from June 11 38, 1932, to April 4 38, 1938
I last saw him alive on April 4 38, 1938. Death is said to have occurred on the date stated above, at 8.40 m a
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	1936
Other contributory causes of importance:	
Bronchitis	1932

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?.....
(Specify city or town, county, and State)
Specify whether injury occurred in Industry, in home, or in public place.
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify.....
(Signed) Edwin J. Krobel, M. D.
(Address) 3635 Gravois Ave

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed Frank H Stroot

Licensed Embalmer No. 2265

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