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

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31214

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3777

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3729 Bellefontaine Avenue (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution -------- (Specify whether years, months or days) In this community 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 3729 Bellefontaine (If rural, give location)
(e) If foreign born, how long in U. S. A.? -------- years.

3. (a) PRINT FULL NAME Mrs. Minnie Frances Cravens Ford
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mr. James Ford
6. (c) Age of husband or wife if alive -------- years
7. Birth date of deceased March (Month) 30 (Day) 1866 (Year)

8. AGE: Years 74 Months 5 Days 28 If less than one day ____ hr. ____ min.

9. Birthplace Salisbury (City, town, or county) Missouri (State or foreign country)
10. Usual occupation At Home
11. Industry or business --------
MOTHER FATHER
12. Name John Cravens
13. Birthplace (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name Mary Jane Nickerson
15. Birthplace (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Mrs Nell Marmon
(b) Address 3729 Bellefontaine
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cemetery
18. (a) Signature of funeral director D. V. Newcomer Sons
(b) Address 1401 Brush Creek Blvd.
19. (a) 9-30-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th year 1940 hour 8 minute 45 P. M.
21. I hereby certify that I attended the deceased from Sept. 14, 1940, to Sept. 27, 1940, that I last saw he alive on Sept. 25, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral apoplexy — Duration: Sept 14, 1940
Due to: Hypertension
Due to: Chronic interstitial nephritis
Other conditions (Include pregnancy within 3 months of death): 131
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature John P. Lewis M.D. (M. D. or other)
Address 3548 Indiana Date signed Sept 27, 40

(Licensed Embalmer's Statement on Reverse Side)

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 ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Kenneth P. Lipp

Licensed Embalmer No. 4128

P. O. Address 1309 Brush Creek

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

If this body is not embalmed, fact should be so stated above.