

No. 2
1-5-42
5-17-39
-I X32875

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22752

State File No.

Registrar's No. **6506**

AUG 14 1942 791
Registration District No.

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 days**
Life (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
(d) Street No. **3168a Easton**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **William Forde**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **Aug.** **12** **1934**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 **11** **17** hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **School-boy**

11. Industry or business.....

MOTHER FATHER
12. Name **Samuel Ford**
13. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Agnes Thomas**
15. Birthplace **Webster Groves, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ames Ford**

(b) Address **4180 N. Belle St.**

17. (a) **burial** (b) Date thereof **Aug. 1st 42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Father Dickson, Cem.**

18. (a) Signature of funeral director **RUSSELL UNDT. CO.**

(b) Address **2732 Pine Street**

19. (a) **AUG 1 1942** (b) **J. F. Prudech**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **29,**
year **1942** hour **4:** minute **15** A. M.

21. I hereby certify that I attended the deceased from **July 17,** 19 **42** to **July 29,** 19 **42**
that I last saw him alive on **July 29,** 19 **42;**
and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculous Meningitis** Duration **4 wks.**

Due to **Lump not affected**

Due to.....

Other conditions **14**
(Include pregnancy within 3 months of death)

Major findings: **JH**
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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature **S. R. Barrett** (M. D. or other)

Address **2601 W. 11th** Date signed **7/29/42**

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

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 *Joel Russell*
Licensed Embalmer No. *4112*

P. O. Address.....

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