No. 2
-11-10-39
5-17-39
P I- X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1942

Registration District No. 554

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4519

State File No. 28407

Registrar's No.

1. PLACE OF DEATH

(a) County: TEXAS

(b) City or town: CABOOL TWP

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1

(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 ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: TEXAS 107

(c) City or town: CABOOL 1

(If outside city or town limits, write "RURAL")

(d) Street No. ____ (If rural, give location) 0

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: INFANT OF ROBERT FORD

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: M 0

5. Color or race: W

6. (a) Single, widowed, married, divorced: S 0

6. (b) Name of husband or wife ____

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

7. Birth date of deceased: MARCH (Month) 14 (Day) 1942 (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 12 hr. ____ min.

9. Birthplace: CABOOL (City, town, or county) 0 (State or foreign country)

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER

12. Name: ROBERT FORD

13. Birthplace: CABOOL (City, town, or county) MO 0 (State or foreign country)

MOTHER

14. Maiden name: ROSE COOPER

15. Birthplace: SUMMERSVILLE (City, town, or county) MO 0 (State or foreign country)

16. (a) Informant: Robert Ford

(b) Address: Cabool mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: MARCH 15 1942 (Month) (Day) (Year)

(c) Place: burial or cremation: Cabool Cemetery

18. (a) Signature of funeral director: Ralph Elliott

(b) Address: Cabool

19. (a) ____ (Date received local registrar) (b) 1239 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH 15 day ____ year 1942 hour 11 A.M. minute ____ M.

21. I hereby certify that I attended the deceased from Mar 14, 1942 to Mar 15, 1942; that I last saw h. ~~him~~ alive on Mar 14, 1942; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Premature Birth	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 159	
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: Lin Edens (M. D. or ~~other~~)

Address: Cabool Mo Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 947768
Date Filed 9-11-42

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28407

Registration District No. Texas Primary Registration District No. 4519 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Cabool

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Infant — Ford

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife

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

7. Birth date of deceased: Mar (Month) 14 (Day) 1942 (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace: (City, town, or county) Cabool (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) March 16-42 (Date received local registrar) (b) Mrs Lon Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day year 1942 hour minute M.

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

Immediate cause of death: Premature Birth — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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 (M. D. or other)

Address Date signed