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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31314**

FILED OCT 6 1943 7  
Registration District No. **3008**

Primary Registration District No. **3008**

Registrar's No. **317**

**1. PLACE OF DEATH:**  
 (a) County Callaway  
 (b) City or town Fulton, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Callaway Co. Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Three Weeks  
 In this community Twenty four Years (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Callaway  
 (c) City or town 7 Mi. N. W. of Fulton, Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. R. F. D. # 2  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** WILLIAM JACOB FORD  
 3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced 2  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)  
 7. Birth date of deceased Dec 29 1866  
(Month) (Day) (Year)

**8. AGE:** Years 76 Months 9 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Milan Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name John Ford  
 13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Sarah Wattenbarger  
 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Raymond Ford  
 (b) Address Fulton, Mo. R.F.D. # 2

17. (a) Burial (b) Date thereof 10/1/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richland Christian Cem.

18. (a) Signature of funeral director Leo Wallace  
 (b) Address Fulton, Mo.

19. (a) 10-1-1943 (b) Joyce Mountjoy  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 29 year 1943 hour 10:20 minute A.M.

21. I hereby certify that I attended the deceased from Sept. 7 1943, 19 Sept. 29 1943, that I last saw him Sept. 29 1943 alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis, associated with chronic Prostatitis. Duration 8 yrs. 3 yrs.

Due to Sudden illness due to impacted fracture of surgical neck of right femur., followed by uremia and and coma. 22 days.

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: X-ray Nov 8 28  
 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) Fall from truck.  
 (b) Date of occurrence Sept. 7, 1943  
 (c) Where did injury occur? Near Fulton, Mo.  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? On road near his farm.

While at work? Yes (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature D. A. Squire (M.D. or other) D.O.  
 Address Fulton, Mo. Date signed 9/30/43

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..... *Leo B. Wallace* .....

Licensed Embalmer No. *3373* .....

P. O. Address..... *Fulton mo.* .....

**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.**

*Joyner*  
OCT - 1943  
State File No. \_\_\_\_\_  
Registrar's No. 317

Registration District No. 47 Primary Registration District No. 3008

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fulton  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME was Jacob 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 Married  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Dec 29 (Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days \_\_\_\_\_ (If less than one day, \_\_\_\_\_ min.)

9. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

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) 10-1-1943 (Date received local registry) (b) Josie Mossinkoff (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

31314