

FILED FEB 9 1945  
141

Registration District No. ....

Primary Registration District No. 5550

Registrar's No. 16

1. PLACE OF DEATH:  
 (a) County Howell  
 (b) City or town Cureall *Go-it-on town*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
At Residence  
 (If not in hospital or institution, write street number or location) 1  
 (d) Length of stay: In hospital or institution no (Specify whether  
 In this community 1 month  
 years, months or days)

3. (a) PRINT FULL NAME Orva Clifford Ford  
 3. (b) If veteran, name war X  
 3. (c) Social Security No. X

4. Sex 0 male  
 5. Color or race white  
 6. (a) Single, widowed, married, divorced 0  
 6. (b) Name of husband or wife  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 29th, 1944  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
6 23 hr. min.

9. Birthplace Ames Iowa  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name George W. Ford  
 13. Birthplace Ozark, County Mo  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Matilda Walker  
 15. Birthplace Cureall, Walker Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Res. W Ford  
 (b) Address Cureall, Mo

17. (a) Burial (b) Date thereof Nov. 20, 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Cureall Cemetery

18. (a) Signature of funeral director North Friends  
 (b) Address Pottersville, Missouri

19. (a) 126-44 (b) Sally Taylor  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Howell 46  
 (c) City or town Cureall 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19th  
 year 1944 hour 6:00p.m. minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Nov. 14th,  
19.44 to Nov. 19th 19.44  
 that I last saw him alive on Nov. 18th, 19.44  
 and that death occurred on the date and hour stated above.

Immediate cause of death Menangitis Cerebral  
 Duration 11 days

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 \_\_\_\_\_  
 Signature A. Thornburgh (M. D. OK)  
 Address West Plains, Mo. Date signed 11/20 1944

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

6600

RECEIVED

District Health Officer No. 5,

District File Number 14654

Date Filed 1.16.46

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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 with the above constitutes grounds for revocation of license.)**

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