S. No. 2
M—5-43
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I X36671

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

#30155

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 16 1945 FEB 6 '45

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4229

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1059

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 917
(If outside city or town limits, write "RURAL")

(d) Street No. 4044 Castleman Ave.
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Chester P. Ford

3. (b) If veteran, name war World War 1

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 3 (Day) 1894 (Year)

8. AGE: Years 50 Months 4 Days 28 If less than one day hr. min.

9. Birthplace Montgomery City Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Fire Dept (Retired)

11. Industry or business City of St. Louis

FATHER
12. Name Owen Ford
13. Birthplace Danville Mo. 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Allie Echard
15. Birthplace Missouri 0 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Allie Ford (Mother)
(b) Address 4044 Castleman Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3 1945 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Wm. J. Robert L&U CO.
(b) Address 1905 South Grand Blvd.

19. (a) FEB 2 1945 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31st year 1945 hour 7:00 minute P. M.

21. I hereby certify that I attended the deceased from 1/25/45, 19, to 1/31/45, 19; that I last saw him alive on 1/31/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Refused.

Duration

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 James J. Shea (M. D. or other)
Address 1515 Lafayette Date signed 2/1/45

(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 Rex E Campbell

Licensed Embalmer No. 3881

P. O. Address St Louis 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.