V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

37417

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 2 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38602

Registration District No. 318 Primary Registration District No. 100 Registrar's No. 9924

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 Days (Specify whether
In this community
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. 2412 Cass
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Robert Ford

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Negro

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 9 (Month) 17 (Day) 46 (Year)

8. AGE: Years Months Days 15 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Renny Ford
13. Birthplace (City, town, or county) Texas (State or foreign country)

MOTHER
14. Maiden name Bessie Mayon
15. Birthplace Sikeston (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Esther M. Sherard, R.R.L.
(b) Address 2601 N. Whittier

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 21 1946 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson
(b) Address City Health Dept

19. (a) NOV 21 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 3
year 1946 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from 10:17 A. M. 9 - 17, 1946 to 5:45 A.M. 10-3, 1946
that I last saw him alive on 10 - 3, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 [signature] (M. D. ~~or other~~)
Address 2601 N. Whittier Date signed 11-15-4

(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.....

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.