S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25514

FILED AUG 15 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7231

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: CITY HOSP. 0
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State KENTUCKY (b) County 999

(c) City or town FT. KNOX 15
(If outside city or town limits, write "RURAL")

(d) Street No. N.R. 0
(If rural, give location) 2

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

If yes, name country

3. (a) PRINT FULL NAME Howard Ford, Sgt. USA. RA36186243

3. (b) If veteran, name war WORLD WAR II

3. (c) Social Security No.

4. Sex M 0

5. Color or race WHITE

6. (a) ~~Single, widowed~~, married, ~~divorced~~ MARRIED!

6. (b) Name of husband or wife Ruth S. Ford

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

7. Birth date of deceased June (Month) 1st (Day) 1907 (Year)

8. AGE: Years 40 Months 2 Days = If less than one day hr. min.

9. Birthplace MASS. 1
(City, town, or county) (State or foreign country)

10. Usual occupation SERGEANT

11. Industry or business U.S. ARMY

FATHER
12. Name — 9
13. Birthplace — 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name — 0
15. Birthplace — 1
(City, town, or county) (State or foreign country)

16. (a) Informant Service Record
(b) Address Fort Knox, Kentucky

17. (a) REMOVAL (b) Date thereof 8-4-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Elizabethtown, Ky

18. (a) Signature of funeral director ROBERT J. AMBRUSTER
(b) Address 6633 CLAYTON Rd.

19. (a) AUG 4 1947 (b) J. F. Brenick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day FIRST
year 1947 hour 247 minute P. M.

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

Immediate cause of death Hemorrhage of Brain due to penetrating gunshot wound of Skull; self inflicted in Pay Toilet
Due to No. 30, Class A. lavatory, in the basement of Union Station on
Due to Aug. 1st, 1947, about 2:45 P.M.

Duration

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence Aug. 1st, 1947

(c) Where did injury occur? St. Louis, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Public Place
(Specify type of place)
While at work? No (e) Means of injury gunshot

23. Signature Thomas J. Callana (M.D. or other) 3
Address Coroner Date signed Aug 4-47

Jefferson City Printing Co.

(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 Arnold W. Schoene

Licensed Embalmer No. 3864

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.