

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26480**

FILED AUG 3 1947
Registration District No. **349**

Primary Registration District No. **6154**

Registrar's No. **28**

1. PLACE OF DEATH:
(a) County **Stoddard**
(b) City or town **Parma Mo, Rural**
(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 **30 yrs**
years, months or days

3. (a) PRINT FULL NAME **Sarah Ford**
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____
4. Sex **female** 7/5. Color or race **black**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Tom Ford** 6. (c) Age of husband or wife if alive **66** years
7. Birth date of deceased **June 3 1902**
(Month) (Day) (Year)

8. AGE: Years **45** Months **1** Days **14** If less than one day _____ hr. _____ min.

9. Birthplace **state of Virginia**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business **unknown**
12. Name **unknown**
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Tom Ford**
(b) Address **Parma Mo, Rt, 7**

17. (a) _____ (b) Date thereof **July 20 47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Dexter Cemetery**

18. (a) Signature of funeral director **Watkins Funeral Dir**
(b) Address **Parma Mo,**

19. (a) **7-24-47** (b) **Kate Howley**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Stoddard** 100
(c) City or town **Parma Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** 18 day
year **1947** hour **6** minute **5** p. M.
21. I hereby certify that I attended the deceased from **July 18 1947** to **July 18 1947**
that I last saw her alive on **July 18 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death
Central Hemorrhage
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **GBA**
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 **W. H. M. S.** (M.D. or other) _____
Address **Parma Mo** Date **July 21 47**

RECEIVED

District Health Office No. 2

District File Number 747-10

Date Filed 7-28-47

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. 2476

P. O. Address..... Wester 77

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.