

FILED DEC 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40059

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 370

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>	
b. CITY OR TOWN <u>Kirksville, Mo.</u>		c. CITY OR TOWN <u>Glenwood</u>	
c. LENGTH OF STAY (in this place) <u>1</u>		d. STREET ADDRESS (If rural, give location) <u>6</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Nursing Home No. 2</u>			

3. NAME OF DECEASED (Type or Print) <u>Kathryn</u>	a. (First)	b. (Middle)	c. (Last) <u>Ford</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 17 1949</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 11, 1898</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Glenwood, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>James Ford</u>	13b. MOTHER'S MAIDEN NAME <u>Juliet Mauck</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Fred Doctor</u>	ADDRESS <u>Kirksville, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Medullary Failure</u>	<u>medullary embolism</u>	<u>4 days</u>
	ANTECEDENT CAUSES	DUE TO (b) <u>auricular fibrillation</u>	<u>1 week</u>
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <u>arteriosclerotic heart disease</u>	<u>15 mo</u>
	II. OTHER SIGNIFICANT CONDITIONS <u>Arteriosclerosis</u>	Conditions contributing to the death but not related to the disease or condition causing death.	<u>?</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4331</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct 7, 1948, to Dec 17, 1949, that I last saw the deceased alive on Dec 7, 1949, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>MT Lutenshuh D.O.</u>	(Degree or title)	23b. ADDRESS <u>Kirksville Mo</u>	23c. DATE SIGNED <u>12-17-49</u>
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24a. REMOVAL (Specify) <u>Dec 19-49</u>	24b. DATE <u>Dec 19 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Good Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Glenwood, Mo</u>
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DATE REC'D BY LOCAL REG. <u>Dec 17-49</u>	REGISTRAR'S SIGNATURE <u>Walter Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Everett B. Head</u>	ADDRESS <u>Lancaster Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED DEC 28 1948
District Health Officer No. 10
Subject File Number 12-49-2172
Date Filed DEC 28 1948

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. 4038

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.